# JOURNAL

*of the*

# AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

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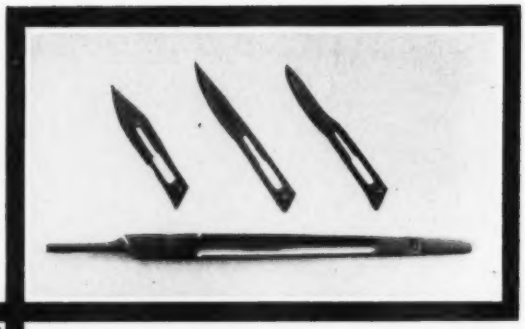

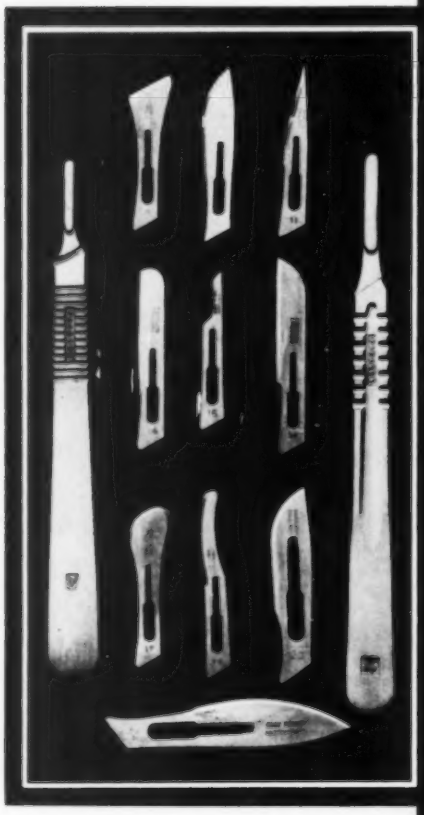

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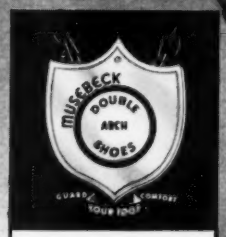

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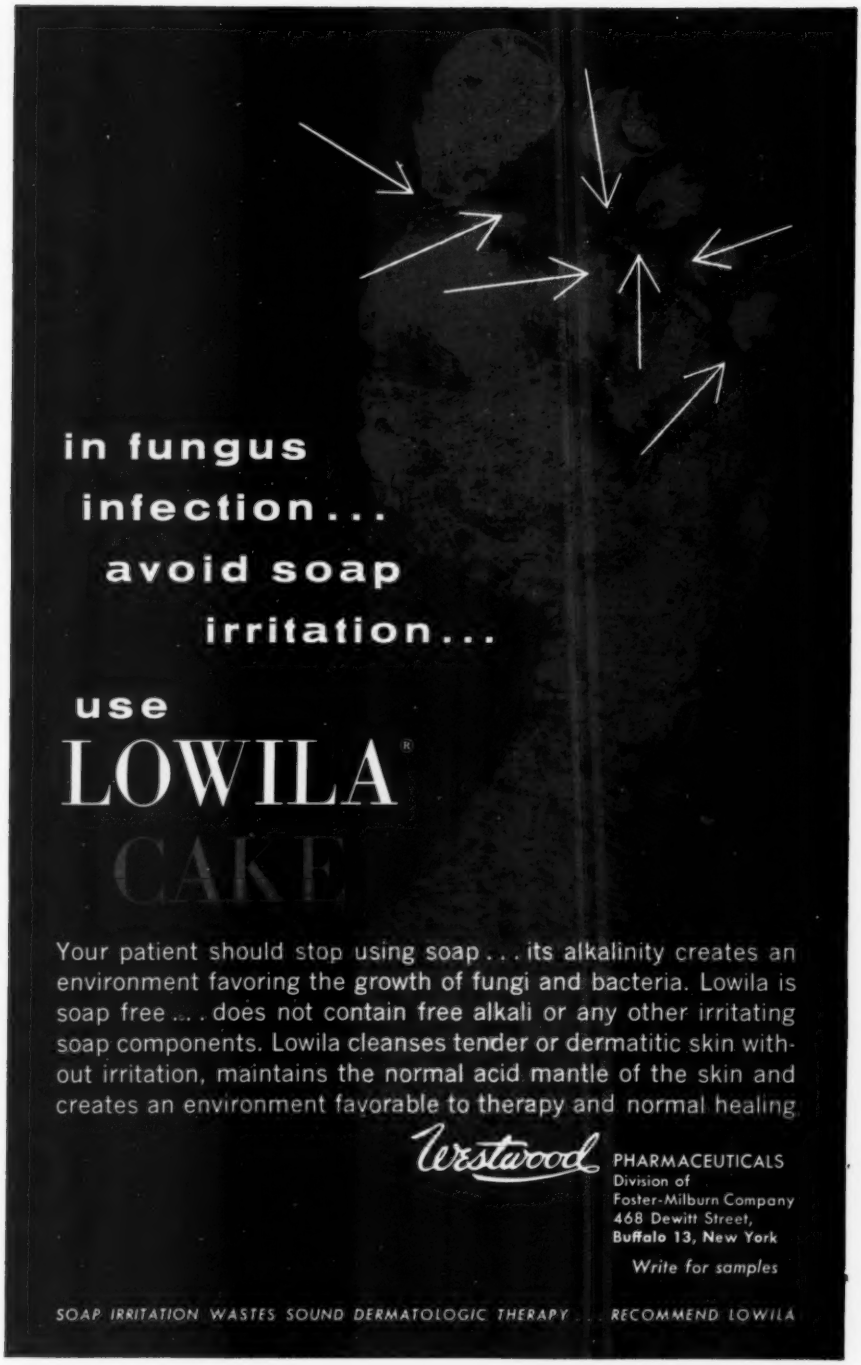
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The Alabama Medical Board of Examiners. **Board Secretary:** Dr. Elizabeth P. Sealy, 34 South Perry Street, Montgomery, Ala.

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The Arizona State Board of Chiropody Examiners will meet for examination in January, 1959, at Phoenix Ariz. **Board Secretary:** Dr. Julius Citron, 40 E. Thomas Rd., Phoenix, Arizona.

**Arkansas**
Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 800 First National Bank Bldg., Fort Smith, Ark.

**California**
The California Chiropody Examining Committee will meet for examination in March, 1959. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, Rm. 530, 1020 N St., Sacramento, Calif.

**Colorado**
Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

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**District of Columbia**
The Board of Podiatry Examiners of the District of Columbia will meet for examination semi-annually in January and July. **Board Secretary:** Saul Shafritz, D.S.C., Dept. of Occupations and Professions, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

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The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

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**Idaho**
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**Illinois**
The Illinois Chiropody Examining Committee. **Superintendent of Registration:** Frederic B. Selcke, Dept. of Registration and Education, Room 109, State House, Springfield, Ill.

**Iowa**
The Iowa State Board of Chiropody Examiners will meet for examination June 8-10, 1959, at the State Office Building, Des Moines, Iowa. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

**Kansas**
The Kansas State Board of Podiatry Examiners will meet for reciprocity and examination in January, 1959, at Kansas University Medical Center, Kansas City, Kans. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. J. Nash, M.D., 384 New Brotherhood Bldg., Kansas City, Kansas.

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The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 728 Starks Bldg., Louisville, Ky.

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**Maine**
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**Maryland**
The Maryland Board of Chiropody Examiners will meet for examination in February, 1959. **Board Secretary:** Dr. S. Jack Kieger, 408 S. Division St., Salisbury, Md.

**Massachusetts**
The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at the State House, Boston, Mass. **Board Secretary:** Dr. Charles H. Thorner, 910 Furnace Brook Parkway, Quincy, Mass.

**Michigan**
The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Walter J. Jeffery, 1950 Madison Ave., S.E., Grand Rapids, Michigan.

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**Missouri**
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**Montana**
The next board meeting of the Montana Chiropody-Medical Board of Examiners will be held when the need arises for reciprocity or examination at the State Capitol, Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

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**Nevada**
The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nevada.

**New Hampshire**
The New Hampshire Board of Registration in Chiropody will meet for examination in December, 1958, at Concord, N. H. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

**New Jersey**
The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. The next examination will be held in January 1959. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

**New Mexico**
The New Mexico State Board of Chiropody will meet for examination on July 11, 12, 1959, in Albuquerque, N. Mex. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N. E., Albuquerque, N. M.

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**North Dakota**
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The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

**South Carolina**
The South Carolina Board of Chiropody Examiners. **Board Secretary:** Dr. Charles W. Clark, 535 Harden St., Five Points, Columbia, South Carolina.

**South Dakota**
The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Dr. Fred D. Rule, 204 Kresge Bldg., Sioux Falls, S. D.

**Tennessee**
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Medical Licensing Board of West Virginia will meet for examination, January 5-6, 1959, at 1800 E. Washington St., Charleston, W. Va. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

**Wisconsin**
The Wisconsin State Board of Examiners will meet for examination, July 14-15, 1959, in Milwaukee, Wis. **Board Secretary:** O. J. Trimborn, D.S.C., 208 E. Wisconsin Ave., Milwaukee 2, Wis.

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**This is Article No. 6 in a series of six devoted to foot problems common to children's feet.**

# Painful

Heel pain is a fairly common complaint in children. Such pain is the result of pathologic conditions either in the bone structure of the calcaneus itself, or in certain adjoining soft tissue structures.

The most common bone lesion in the child's heel is the disorder commonly referred to as "Sever's disease," or apophysitis. This is an avascular necrosis involving the calcaneal epiphysis. The calcaneus is the only tarsal bone having a regular secondary osteogenic center (epiphysis). This center normally appears between the 5th and 12th years and unites with the body of the bone between the 12th and 22nd years.[1] Sever's disease, like all of the osteochondritides, involves growing bone; the age incidence is usually between 10 and 15 years,[2] at which period the rate of osteogenesis in the area is at its peak.

Clinically, the disorder is characterized by pain at the posterior as-

**Continued on opposite page**

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# Heels

by A. Rubin, D.S.C.*
John T. Sharp, D. S. C.†

pect of the heel, with an accompanying antalgic limp. The foot is often held in slight equinus during ambulation, since this position tends to relax the tendoachilles to some degree, and thus places less tendonous stress upon the calcaneus. There may be a slight swelling in the back of the heel, and pain is aroused by palpation in this area. Sever's disease is far more prevalent in boys than in girls, probably because of the former's greater indulgence in activities which predispose the part to trauma.

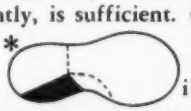
Roentgenologic studies of the heel reveal increased epiphyseal density and usually some fragmentation. It is important to realize that x-ray findings in Sever's disease are of little diagnostic importance unless supplemented by clinical symptoms. This is true because the posterior calcaneal epiphysis is normally an area of irregular mineralization. Further, the epiphysis here generally evolves from multiple centers, which may lead to an erroneous diagnosis of fragmentation.

The treatment of apophysitis consists of the use of measures designed to lessen the degree of tendonous pull upon the diseased bone. The simplest method for accomplishing this is to place an elevation in the heel of the shoe.(See illustration 1.) In refractory cases, plaster-of-paris casting in slight equinus may be indicated. It is important to remember that subsidence of clinical symptoms does not necessarily indicate a complete cessation of the disease process. Consequently, the part should be under treatment until x-ray evidence indicates a return of the part to normalcy.

ill. 1. Soft pad made of sponge rubber to cushion the affected section of the heel.

A frequent cause of pain on the plantar surface of the heel in the child is foot strain. It will be remembered that the posterior attachment of the main portion of the plantar fascia and long plantar ligament is the tuberosity of the calcaneus. The altered posture present in cases of foot strain places increased tension upon the posterior attachments, with the result that this area becomes painful. There is tenderness on palpation over the calcaneal tuberosity, and the patient usually limps on walking. Relief may be attained by eradication of the underlying postural problem with adequate shoe therapy measures.

Another common cause of heel pain in children is a bursitis of either the retrocalcaneal or retroachilleal bursa. These are located at the back of the heel, and are, respectively, just in front of, and immediately behind and above the insertional section of the tendoachilles. Bursitis in these areas is usually a result of wearing a shoe with a poorly fitting counter. There is pain, redness, and swelling in the involved area, and a callus may be present in cases of long standing. Treatment consists of the relief of pressure, with suitable padding and rectification of shoe-fit. Frequently a pad in the heel-seat, to raise the rear foot slightly, is sufficient. (See illustration 2.)



ill. 2. Elevation of the heel of from 1/2" to 3/4", addition of 1/8" to 3/16" medial heel wedge.

Less common causes of painful heel in the child include osteomyelitis, periostitis, bone tumors, helomata, and verrucae.

REFERENCES

(1) Caffey, J.: Pediatric X-ray Diagnosis. Chicago, Year Book Pub., 2nd ed., 1950.

(2) Dickson, F. D. and Diveley, R. L.: Functional Disorders of the Foot. Philadelphia, Lippincott Co., 3d ed., 1953.

*Secretary, National Association of Chiropodists, and Editor of its Journal. Formerly Director of the Foot Clinics, and Professor and Chief of Orthopedic Dept., Illinois College of Chiropody and Foot Surgery.

†Professor of Chiropodal Pediatrics, Temple University, School of Chiropody.

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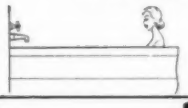

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**1. Prentice, H. and Brezak, S.: Jrnl. Amer. Podiatry Assn. 48:191, (May) 1958.**
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JOURNAL

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THE OFFICIAL PUBLICATION OF THE PODIATRY-CHIROPODY PROFESSION

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# THE MANAGEMENT OF CUTANEOUS MONILIASIS WITH NYSTATIN

LOUIS J. ARANCIA, Pod.D.*
Brooklyn, N. Y.
SAMUEL BREZAK, Pod.D.*
Brooklyn, N. Y.
ROYAL M. MONTGOMERY, M.D.
New York, N. Y.

Moniliasis is an acute, subacute or chronic mycotic infection caused by Candida Albicans which may involve any part of the body. The infection has no predilection for either males or females and occurs at all ages. The organisms are frequently found on the skin or mucous membranes of normal healthy individuals. Certain conditions of altered metabolism such as debilitation, obesity, diabetes mellitus, hyperhidrosis and pregnancy predispose to cutaneous infection.

Moniliasis may be either a localized or generalized cutaneous disease, may involve the mucous membranes or it may be a systemic infection.[1] Since this paper deals with cutaneous moniliasis, only these entities will be described.

A. Cutaneous Localized – The parts of the body most frequently involved are the nails (onychia), the cuticle (paronychia) or the intertriginous surfaces. Infections of the nails and cuticles resemble an acute pyogenic process with pain, redness and swelling but without suppuration. Because of this, the nail plate appears contracted. The cuticle becomes thickened and the nail becomes hard, transversely ridged, and thickened especially in the lateral aspect. The absence of detritus under the nail and the failure of the nail to become brittle or lose its luster differentiates it from infections caused by the dermatophytes. Localized infections of the skin due to Candida albicans are usually sharply demarcated patches, erythematous and with undermined borders involving intertriginous surfaces. At times there are satellite pustules. The lesions tend to chronicity and are resistant to treatment. In the feet it is seen between the 4th and 5th toes bilaterally, although other toes may be involved. The intertriginous spaces are white and macerated and the adjacent sides of the toes are bright cherry red in color and are tremendously pruritic in the acute phase.

B. Cutaneous Generalized—This is usually a chronic exfoliative type of dermatitis

* Hospital for Special Surgery, Division of Podiatry. Many of these patients were seen at New York Hospital, Vascular Clinic in consultation with William T. Foley, M.D., Chief of Clinic.

which may involve any portion of the skin, but generally occurs where skin surfaces are contiguous. A more serious type of infection is widespread in character. This sometimes accompanies infections of the mucous membranes or represents an extension from a localized cutaneous focus.

With the widespread use of such antibacterial agents as penicillin, other mycin derivatives and steroids, moniliasis of the skin has become increasingly prevalent. It is a disease that in the past has been difficult to treat. Cutaneous moniliasis will at times respond to the local use of potassium permanganate soaks, gentian violet solution, or ammoniated mercury ointment[2]. There are numerous other agents for topical use and other modalities of therapy that have been used in the treatment of this disease with indifferent success. In addition, many of the therapeutic agents have certain disadvantages such as staining of tissue, side effects, or difficulty of administration.

Recently a new antifungal agent, nystatin, has become available for clinical use. It was originally isolated from Streptomyces noursei by Hazen and Brown[3]. It possesses in vitro activity against both saprophytic and pathogenic fungi, including Candida albicans and in vivo against Candida albicans, Histoplasma capsulatum and Coccidioides immitis[4].

Wright et al[5] reported good to excellent response with topical use of nystatin in 63 patients with cutaneous moniliasis. Robinson[6] reported that 15 out of 18 patients with monilial paronychia responded to treatment with nystatin in ointment form. There was a reduction of inflammation and edema within a week. With the application of an ointment containing neomycin and gramicidin the remaining patients responded to treatment. In this study onychomycosis did not respond to therapy. In general, according to clinical reports, nystatin applied either as an ointment or a solution, has failed to influence cutaneous mycotic infections caused by organisms other than Candida albicans.

This paper deals with an evaluation of nystatin alone or in combination with other drugs in the treatment of various forms of cutaneous moniliasis and is the first devoted mainly to the feet especially in patients with diabetes and arterial insufficiency due to arteriosclerosis obliterans.

## Materials and Methods

The series consists of 42 patients†. There were 34 cases of cutaneous moniliasis of the feet of which 23 were patients with diabetes and arterial insufficiency due to arteriosclerosis obliterans and 11 patients with normal vascular systems. There were also 8 cases with cutaneous moniliasis elsewhere on the body of which 3 were patients with diabetes and arterial insufficiency due to arteriosclerosis obliterans, and 5 were patients with normal vascular systems.

The diagnosis of moniliasis was determined by the clinical appearance and location of the lesion. Additional confirmation was obtained by cleansing the skin lesions and diseased nails with 70% alcohol, scraping with a sterile scalpel and the specimens cultured on Sabouraud's agar. With this media the colonies appear quickly, are slow growing, flat, irregular, lightly furrowed, moist, shiny, cream colored and have a characteristic yeasty odor. Old cultures appear dry and cerebriform.

The following preparations* with nystatin were applied topically:

1. Drug A—
   a) Ointment—100,000 units per gram of nystatin in a plasticized petrolatum base (plastibase).
   b) Powder—100,000 units per gram of nystatin in talc.

* Drug A was supplied as Mycostatin Ointment & Powder; Drug B as Mycostatin-Spectrocin Cream; and Drug C as Myconef Cream by the Squibb Institute for Medical Research, New Brunswick, N. J.

2. Drug B — Cream containing 100,000 units of nystatin per gram combined with 2.5 mg. of neomycin and 0.25 mg. of gramicidin per gram.
3. Drug C — Cream consisting of 0.1% of fluorohydrocortisone acetate per gram and Drug B.

The cutaneous infections were treated with application of ointments and creams twice daily. In cases in which powder was used in conjunction with the ointments, the powder was used in the morning and the ointment at night. Ordinarily treatment periods varied from 1 to 8 weeks. The clinical responses were graded as poor, good, and excellent.

## Results

The results of treatment are summarized in tables 1, 2, and 3.

There were 42 patients with cutaneous moniliasis. Of these, 27 showed an excellent response, 13 were classified as having a good response, and 2 as having a poor response. Of the 42 patients, 34 had cutaneous moniliasis in the feet. Of these, 22 showed an excellent response, 11 were classified as having a good response, and 1 as having a poor response. Of the 42 pa-

**TABLE 1**

Results of Treatment of Nystatin Alone or in Combination in 42 Patients with Cutaneous Moniliasis.

| Form of Drug | Period of Therapy | Patients† No. | Results | | |
|---|---|---|---|---|---|
| | | | Excellent | Good | Poor |
| Drug A—Ointment | 1-8 weeks | 14 | 7 | 6 | 1 |
| Drug A—Ointment & Powder | 1-6 weeks | 6 | 4 | 2 | 0 |
| Drug B | 1-4 weeks | 10 | 7 | 3 | 0 |
| Drug C | 1-4 weeks | 12 | 9 | 2 | 1 |
| Totals | | 42 | 27 | 13 | 2 |

**TABLE 2**

Results of the Treatment With Nystatin Alone or in Combination in 34 Patients with Cutaneous Moniliasis of the feet.

| Form of Drug | Patients No. & Conditions** | Results | | |
|---|---|---|---|---|
| | | Excellent | Good | Poor |
| Drug A—Ointment | 8 V | 5 | 2 | 1 |
| | 4 N | 1 | 3 | 0 |
| Drug A—Ointment & Powder | 3 V | 3 | 0 | 0 |
| | 3 N | 1 | 2 | 0 |
| Drug B | 4 V | 2 | 2 | 0 |
| | 2 N | 2 | 0 | 0 |
| Drug C | 6 V | 5 | 1 | 0 |
| | 4 N | 3 | 1 | 0 |
| Totals | 34 Patients | 22 | 11 | 1 |

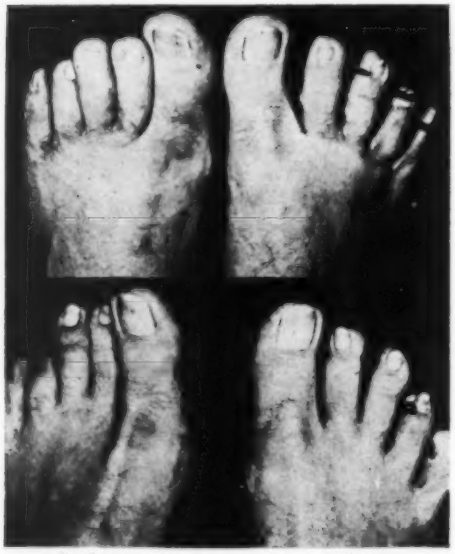
** V—Patient with Diabetes or arterial insufficiency due to arteriosclerosis obliterans. No differentiation has been made between a patient with diabetes or a patient with vascular disease since it is the vascular complications of diabetes that is of importance. N—Patient with normal arterial flow.

**TABLE 3**

Results of Treatment with Nystatin Alone or in Combination of 8 Patients with Cutaneous Moniliasis Elsewhere in the Body.

| Form of Drug | Patients No. & Condition | Results | | |
|---|---|---|---|---|
| | | Excellent | Good | Poor |
| Drug A—Ointment | 2 N | 1 | 1 | 0 |
| Drug B | 1 V | 1 | 0 | 0 |
| | 3 N | 2 | 1 | 0 |
| Drug C | 1 V | 0 | 0 | 1 |
| | 1 N | 1 | 0 | 0 |
| Totals | 8 Patients | 5 | 2 | 1 |

tients, 8 had cutaneous moniliasis other than in the feet. Of the 8 patients, 5 showed an excellent response, 2 a good response and 1 showed a poor response. As can be seen the results of the treatment of the whole group was equal in ratio of therapeutic response as the group divided.



Before After

N.K., 47, Male, Normal Arterial Flow—Duration: 5 to 6 weeks. Patient had redness and maceration between toes bilaterally. Culture was positive for Monilia albicans. Improved rapidly on Drug C. After 2 to 3 weeks there was only slight maceration between 2 toes. Cleared in 4 weeks of therapy.

In general, the treatment period was almost 50% shorter when nystatin was used in combination with other drugs than were the treatment periods with nystatin alone. In the group using Drug C, erythema decreased rapidly and symptoms of itching and burning frequently subsided within 24 hours. This response is probably due to the addition of 0.1% of fluorohydrocortisone acetate per gram to Drug B. In one particular case, after 1 week's use of nystatin alone, there was no therapeutic response. After changing to Drug B, the condition improved rapidly and cleared after 2 weeks of therapy. This leads to the possibility that the therapeutic responses to the nystatin alone may be influenced by secondary infection and the use of antibacterial agents may prevent this inhibition by the secondary infection. In one particular case after excellent results with Drug C, the patient used Drug C in an ointment rather than a cream base. In this particular case there was a flare-up of the condition. Probably therapeutic responses to the drug may also be determined by the vehicle used.

In summary, in the entire group of 42 patients with moniliasis treated with nystatin alone or in combination, the lesions healed promptly in 27 and the results were classified as excellent. They healed more slowly in 13 patients and the results were classified as good, and in 2, the results were poor. There were no instances of allergic contact dermatitis or of primary irritation after treatment.

### Comment

With 2 exceptions, the response to treatment was either good or excellent. The lesions ordinarily disappeared from 2 to 4 weeks, although in some patients 6 to 8 weeks were required for a cure. Clinical relapses were infrequent, though some did occur, most often within 1 week after discontinuance of therapy.

The clinical effectiveness was influenced by whether the nystatin was used alone or in combination. The lesions cleared more rapidly when the drug was used in combination.

### Summary

Nystatin, alone or in combination, was used topically in the treatment of 42 patients with infections due to Candida albicans with good to excellent results in all but 2 of them. Relapses were infrequent but did occur. The addition of antibacterial agents to the nystatin shortened the course of therapy. The use of fluorohydrocortisone rapidly relieved the itching and burning, and the erythema decreased rapidly. There were no instances of allergic contact dermatitis or of primary irritation following treatment.

*7725-4th Ave., 5704-18th Ave.*
*57 W. 57th St.*

### References

1. Moss, E. S., and McQuown, A. L.: Atlas of Medical Mycology, Baltimore, Williams & Wilkins Co., 1953, pp. 48-59.
2. Conant, N. F., and others: Manual of Clinical Mycology, ed. 2, Philadelphia, W. B. Saunders Company, 1954, p. 191.
3. Hazen, E. L., and Brown, R.: Two Antifungal Agents Produced by Soil Actinomycete, abstracted, Science 112:423 (Oct. 13), 1950; Fungicidin, Antibiotic Produced by Soil Actinomycete, Proc. Soc. Exper. Biol. & Med. 76: 93-97 (Jan.), 1951.
4. Brown, R.; Hazen, E. L.; and Mason, A.: Effect of Fungicidin (Nystatin) in Mice Injected with Lethal Mixtures of Aureomycin and Candida Albicans, Science 117: 609-610 (May 29), 1953. Hazen, E. L.; Brown, R.; and Mason, A.: Protective Action of Fungicidin (Nystatin) in Mice Against Virulence Enhancing Activity of Oxytetracycline on Candida Albicans, Antibiotics & Chemother. 3: 1125-1128 (Nov.), 1953. Campbell, C. C.; Hodges, E. P.; and Hill, G. B.: Therapeutic Effect of Nystatin (Fungicidin) in Mice Experimentally Infected with Histoplasma Capsulatum, ibid. 4: 406-410 (April), 1954. Newcomer, V. D., and others: Evaluation of Nystatin on Course of Coccidioidomycosis in Mice, J. Invest. Dermat. 22: 431-440 (May), 1954.
5. Wright, E. T.; Graham, J. H.; and Sternberg, T. H.: Treatment of Moniliasis with Nystatin, J.A.M.A. 163: 92-94 (Jan. 12), 1957.
6. Robinson, R. C. V.: Nystatin in the Treatment of Cutaneous Moniliasis, Monographs of Therapy, Squibb Institute of Research, 2: 55-59 (March), 1957.

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## EMOTIONAL ASPECTS OF YOUTH FITNESS

JAMES PATRICK SCANLON, M.D.
Washington, D. C.

### Introductory Remarks

THE medical specialty of psychiatry welcomes this opportunity to participate in the Association's annual program, dedicated this year to youth fitness. Psychiatry is interested in the individual and the significant people surrounding him at all ages and in every cultural milieu. As a specialty we approach the individual from a total or holistic standpoint. This means that the question of emotional fitness can only be understood in the framework of both the psyche and the soma. How these interacting units operate together, or oppose each other, must be assayed in a fractional analysis. From this we realize the reasons for efficient or inefficient adjustment of the complete organism to its environment. It would be erroneous to attempt to rationalize a moderate depression

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on the basis that the individual's "feet hurt." However, youth fitness encompassing the eras of childhood, adolescence and early adulthood is of special interest. This special interest in the emotional fitness of the young revolves about the tremendous opportunity offered in the field of Preventive Psychiatry. At the same time greater dividends may be expected where corrective measures through psychotherapy are applied early to the damaged personality rather than later or late. Chronicity does not militate against salvagability but is rather like the old adage "an ounce of prevention is worth a pound of cure."

### General Considerations

The developmental years merit our particular attention since the emotional growth, concomitantly paralleling the physical growth, is influenced from birth by the significant people in the life of the individual.

Significant people would be identified as parents or foster (substitute) parents, siblings, teachers, members of the clergy, friends, or anyone who has had a close or special relationship to the growing individual.

Emotionally traumatic or damaging experiences occurring during the early or late formative years, with any or all of these significant relationships, may leave a permanent imprint on the unfolding personality.

If the psychic trauma is severe enough and of a repetitive character the resulting emotional organization will necessarily be warped in certain individuals.

It will lead to chronic emotional disturbance of some degree.

Any individual suffering from chronic emotional disturbance fails to fulfill an ideal concept of fitness in the psychological assessment. Since everything in the psychic life is quantitative (degree) the manifestations of emotional disturbance may be quite subtle and go unnoticed by the inexperienced in our day-to-day living.

### Marks of Maturity and Immaturity

Modern or dynamic psychiatry has advanced to the point that it understands in large measure the human being's emotional growth toward maturity.

Likewise, there is increasing knowledge of intra-personal relationships to ascertain what obstructs this growth thus leading to emotional immaturity.

As Plato admonished us to "avoid the extremes" this advice, the origin of which has been lost in the mists of antiquity, would still best serve our purpose here today.

The extreme of psychological immaturity or maladjustment, observed in the schizophrenic concerns us only indirectly since this is a gross form of the emotional misfit.

Likewise, the organic syndromes of Senile Deterioration or Mental Deficiency, both demonstrating regressive features due to somatic damage, would again be in the same category.

Although the psychotic patients occupy over 500,000 hospital beds per day, they consist of a mere fraction as compared to the neuroses, which approximate more the average and thus interest us in terms of an approach to the ideal concept of emotional fitness. To illustrate this point it might be stated that neurosis results from the emotional trials and tribulations of living from which no human being escapes.

Understanding the neuroses gives us an insight into the so-called normal or average individual with his overt and hidden hates and loves, fears and hopes, which he himself may only vaguely appreciate, if at all. In essence it is to know the motivations which drive all men, thus producing alleged normalcy or deviations from the same criteria.

Neurosis represents a failure in adapta-

tion, basically emotional, in which the personality relinquishes mature reactions and partially regresses to earlier or immature patterns of adjustment. Some individuals reflect such a faulty emotional development that their psychological functioning is always highly precarious even when the environment is most favorable.

Other individuals, being more mature, may react with neurotic symptoms only when exposed to the most severe and prolonged stress as witnessed in combat conditions of World War II.

Both civilian and military clinical experience has established the psychological fact that every individual possesses a specific emotional vulnerability. Prolonged stress, of sufficient intensity, reveals any man's emotional Heel of Achilles, a psychological threshold he cannot exceed. This is true since the human organism is a finite being and therefore cannot attain perfection but only valiantly strive toward it.

Under prolonged stress, frustration, pain, fear or excessive physical taxation every animal organism reacts with a physiological and psychological mobilization for flight or fight. The associated subjective feeling (emotion) is either one of anger and/or fear, which if expressed outwardly may produce aggressive attack or the opposite in attempts to withdraw or retreat.

If, due to a specific emotional vulnerability combined with a weakening of the inner powers of control, these associated emotional reactions are automatically banished from conscious awareness (repressed) they can then be indirectly expressed in a variety of substitute equivalents.

These substitute forms are psychological and physiological reactions of a regressive type leading to unconsciously motivated misbehavior, partial return to childish patterns of adjustment, free-floating anxiety, phobias, inner tension, nightmares, and a host of other "neurotic" symptoms.

In Psychosomatic medicine, for instance, these same repressed emotional forces can be observed in various clinical syndromes. A brief and over-simplified example would be psychologically banished fight impulses indirectly and physiologically expressed (somatized) in terms of hypertension. On the other hand, banished flight impulses are often vicariously expressed in the form of a Gastric Ulcer, Mucus and Spastic Colitis and the functional diarrheas.

In another diagnostic category, the strictly emotional illness, a combination of both aggressive and withdrawal drives, may unconsciously motivate the prevalent syndrome of depression.

From various sources of clinical experience we can dynamically conclude that the mature (fit) individual possesses a relatively complete or adult emotional development with a high degree of adaptability, low regressive tendencies and a minimal quantity of emotional vulnerability from his childhood conditioning.

The immature individual, on the other hand, shows an internal predisposition toward relinquishment of adult responsibility, a tendency toward regressive or infantile levels of adaptation, due to a higher degree of emotional vulnerability combined with an incomplete personality development (the misfit). These identifying marks of maturity or immaturity result from the individual's emotional conditioning in childhood. In this regard the attitudes and feelings of the parents toward the child is the pivotal point rather than vice versa. The matrix of the personality is forged in the crucible of the parent-child relationship and secondarily with other significant people during the formative years. Specific characteristics of emotional fitness resulting from the parent-child relationship is the equation of psychological dependency or independence. The latter is achieved by emotional eman-

cipation from the protective parents in phases and stages of growth.

As we all realize the embryonic life, neonatal state, and the early childhood years are necessarily parasitic and then later almost complete dependence for the child in the relationship with the parents. With school, playmates in the community, advancing physical growth and the associated educational process, this dependency is gradually diluted.

With early and late adolescence nature's trend toward independence eventually reaches fruition, although this must be achieved over the inclination to cling, to be protected, to be supported and to enjoy the childhood absence of major responsibility.

Unfortunately, in the animal kingdom the human being requires a much longer period of dependency, so that we sometimes remain children for so long that we never get over it. The psychological "pull-back" toward the pleasures of childhood exist consciously, or certainly unconsciously, throughout the life-span. How often do we overhear the wishful longing to return to the scenes of boyhood, or girlhood, in the inadvertent expression—"Brother, those were the good old days." Nature's drive toward maturity and independence may be obstructed, impaired or even arrested at any and all stages by emotionally immature, therefore unfit parents.

This damage to the emotional organization of the growing child, or youth, is usually perpetrated by the parents due to emotional problems of their own and takes myriad forms.

For example, the parents may unwittingly play upon or foster the child's early tendency to cling, and attempt thereby to dominate or bind the offspring to them.

On the other hand the elders may forever try to protect the fledglings throughout life, even when they are adult, married and financially self-supporting. Other instances show parental interference through forcing responsibility prematurely upon the young, thus producing the unconscious longing to satisfy the degree of dependency that would otherwise be average for that age.

In any event the path to emotional fitness via maturation is obstructed by too little satisfaction of the normal dependency needs, or the forced feeding of precipitous independence.

Either way the resultant excessive degree of unresolved dependence continues to be reflected in subsequent relationships throughout life. These reflections may be manifested by the repeated need to be supported, often "rescued," by relatives, friends, or employers from a variety of life-situations when increased or unexpected stress occurs.

Life's demand for an adult response will evoke the opposite through a partial regression to neurotic symptoms, alcoholism, or delinquent behavior.

At face value the emotionally unequipped person reacts inappropriately and anachronistically due to psychic forces beyond his conscious control. Another characteristic arising from problem parents and problem environments is an alteration of the give-get balance which parallels the dependence-independence equasion.

If, as described, the growing child is emotionally deprived or over-indulged he may then constantly expect to receive from other significant people and thereby suffer an impairment of his capacity to give. Any frustration of the expectation to receive, or of the enjoyment of giving, leads to anger which in turn produces unhappiness, dissatisfaction and possible depression, alcoholic excess, neurotic reactions and even antisocial behavior.

These are the constricted personalities who are often able to give material things to their spouse or children, but psychologically blocked from giving of themselves

in terms of the ability to freely give love. In turn, where a child feels a lack of parental love, or unloved, it cares little about self-control and emulating the socialized elders.

Another characteristic of emotional fitness is a healthy freedom from the frequent constellation of inferiority feelings, compulsive competitiveness and excessive egotism. These traits all exceed the average. Since much of the child lingers underneath in the adult it remains the source of guilt feelings for failure to be completely adult. This leads to the widespread existence of inferiority feelings and the frantic psychological effort to *deny* these infantile wishes through compensatory strivings.

These strivings take the form of the prevalent drive for prestige, power, wealth, acclaim and all the social trinkets which the child associates with the parents.

The adult often unconsciously repeats, especially toward persons in authority, much of the childhood pattern of relatedness with attendant feelings of inferiority, inadequacy or dependency.

These underlying childish feelings constitute an affront to the adult Ego or Self-esteem and are necessarily repudiated and denied through competition with parents and siblings or their later psychological substitutes. The psychological substitutes are superiors and co-workers, but the latent hostility is a cause for further guilt, anxiety and inferiority feelings. This situation calls forth a greater re-application of the compensatory defenses. A vicious circle is thereby established. For mankind this is often a mad struggle to become God while pathetically remaining a beast.

Man fails to perceive the real goal in life as emotional maturity and therefore seldom achieves it.

Difficulties in living result then from the "human element" which we can now more specifically define as the childish remnants in human nature. The accent on "Youth Fitness" is indeed appropriate.

Still another characteristic of the emotionally qualified individual is derived from the training necessary for the human animal to laboriously attain socialization and domestication. In this tedious process the parental attitudes and standards, ethical and social ideals and the experiences of living with others are incorporated within the individual's psychic structure. The conscience (super-ego) is thus formed through the mechanism of introjection or inculcation.

If properly integrated the conscience, as a regulating and restraining influence upon behavior, is certainly a positive force. The ultimate effect is to aid us in the direction of adult, moral and mature relatedness, consistent with the religious teachings of all the Ages. Within average limits to be "conscientious" is to be adult. Ascending the heights from different directions, here psychiatry and religion meet at the summit in mutual agreement. We have long since learned that because of too little or too lax training the individual may become an infantile, impulse-prone older person. The inhibited individual results from too early or too harsh training. The conscience has become, in turn, too strict and remains essentially pathological. Inconsistent training produces confusion and results in indecisiveness.

Despite heroic educational efforts of psychiatry, pediatrics and general medicine, much ignorance still pervades the domain of child-rearing.

In the family circle we often find the parents using themselves as the yardstick to be applied along with the hickory stick to the growing child. The amorphous and pliable psyche must be fitted to some pre-conceived mold. This is, indeed, the modern version of the Procrustean Bed of Greek mythology.

The skein of this parental attitude is

basically conscious and unconscious in origin and fails to realize, despite intelligence, that the child grows through love and identification. It is not what the parent *says* but what the parent *does* that is crucial. There is no substitute for good judgment, and emotional thinking is no substitute at all. The child, in God's wisdom, possesses a tremendous drive from within to navigate each higher level of adjustment, to mature to adulthood. Given patience and understanding tolerance it will come to final fruition in its own good time.

If it were not for this salvaging feature, provided through Mother Nature, we might have just cause to be morbid about the human scene.

The preponderance, however, is weighted in the direction of maturity, with neurosis in the minority but many gradations in between.

For this reason civilization has advanced slowly, barely inching forward over the long centuries.

Time does not permit us to examine in great detail the multiple facets of the emotionally qualified personality.

However, some attention should be given to the role of sexuality since this is a powerful force playing a dynamic role in the emotional development. Likewise, it is an expression of the individual's emotional organization and his degree of maturity or immaturity. Sexuality, in the psychological sense, may serve as an outlet for all kinds of feelings and impulses. It may express loneliness or drain hate and anger. The sex athlete of the Don Juan order is really acting out his emotional need to repeatedly bolster his prestige and flagging of self-esteem.

Like a child, it is used for play and pleasure and not, therefore, properly integrated into the realm of affection. The prostitute, tramping through the pages of history as a "necessary evil," is, nonetheless, a gruesome example of sick behavior.

Where the sexuality matures with the rest of the personality, an adult attitude prevails. It becomes an instrument for the expression of love and affection, for procreation and the satisfactions derived from parental responsibility. This is a proper balance and the two different modes of living provide a striking contrast between the adult and the infantile, between the emotionally equipped and the ill-equipped.

Where we have suffered two world wars within the short span of twenty-five years we should certainly give some attention to human hostility.

It is, indeed, more deadly than the Hydrogen bomb. Deficiencies in emotional development, where the individual internally feels constantly threatened, leads to persistent feelings of anger and hate. Man's greatest danger becomes man himself. For these are the volatile emotional elements from whence come wars, crime, violence and the gamut of human atrocities. The origin is unresolved emotional problems of childhood, the persistence of infantile hates and rages, carried into adulthood and not outgrown. Basically Hitler was an angry boy and look what happened. In day-to-day living the internally generated hostility may be vented outwardly through displacement. This means transplanted from mistreating parents or siblings to innocent victims later in the form of wife, children, friends or anyone who may serve as a target for revenge. Likewise, the hostility may be turned against the self and emerge masochistically in multifold forms of self-punishment, self-defeat or a generally mismanaged life. Hostility of murderous proportions may erupt in homicide or suicide. Like purulent material it must erode to the surface and is the saga of man against himself. It is also the story of human misery self-induced in all its sadistic horror. Against this black background of human

inhumanities is heard the clear Christ-like, clarion call to moderation, consideration and the Sermon on the Mount.

Like the oceanic tides, epochs and men ebb and flow, but the mature, healthy attitude prevails. It is not crucifixions and self-crucifixions but creative, normal aggressiveness, parental solicitude, which is constructive and not cruelly destructive. This is the spectral ray of hope piercing the mushroom curtain of the awesome Atomic Age.

With the sands of inexorable time running out we should mention the attribute of flexibility and adaptability. Where this characteristic is of high quality we have maturity. Where the personality is rigid and inflexible we are dealing with some degree of immaturity. The child learns from the significant people who reared it what to expect from other people. In some people the childhood reactions remain powerfully fixed, and dominate the behavior. These fixed reactions tend to be repeated over and over throughout life and are inappropriate because they originate with early traumatic emotional experiences.

Given proper conditions the emotional maturation will unfold spontaneously. A prevalent parental mistake is to force their will upon the child. Unconsciously the parent often tends to treat the children and spouse as they themselves were treated. They identify with the "tyrant."

A last attribute of maturity is a firm grasp of reality. Parent example to avoid deceit and illusion is most important but unconscious phantasies connected with significant people also play a dynamic role.

This, however, is not within the reactive neuroses and would, therefore, take us beyond the scope of our interest today.

### Conclusion

In summary we can state that the emotional fitness of youth derives from the significant people surrounding the individual in the developmental years. We have seen where the personality is forged in the matrix of the child-parent relationship.

The glimpses presented here of the vicissitudes of personality growth toward maturity are not new. They have long been recognized by observers of the human scene. They need, however, to be articulated again in clinical terms and in the medium of psychiatric education.

It is hoped that there has been something gained in this re-statement.

*1922 Eye Street N.W.*

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## MANAGEMENT OF PLANTAR VERRUCAE VIA EXCISION AND CURETTAGE*

LEONARD H. LERNER, A.B., D.S.C.†
Warwick, R. I.

### Introduction

PLANTAR verrucae, like varicose veins, have enjoyed cyclical favor in choice of therapy over the years through a wide variety of techniques. Total destruction, interruption of the vascular supply, or complete excision of the lesions have been the common denominator of most procedures attempted. More recently a specific intradermal Vitamin A preparation (Keramin®[1] Injection) has been utilized by Steinberg[1] in resistant cases with gratifying success. In addition a surgical procedure has been described by Du Vries[2] for use in markedly

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† Podiatry Clinic, Orthopedic Service, Madigan Army Hospital, Tacoma, Washington.

®[1] Campbell Pharmaceuticals

resistant plantar keratoses resembling verrucae in appearance and symptomatology, which involves amputation of the plantar condylar prominences of the affected metatarsal head.

Although all techniques employed to date possess varying degrees of merit, the end results from therapy have often fallen below expectations of satisfactory response. The percentage of success has ranged generally in the 70% to 85% bracket for the most part in the long run.

Notable exception to this average has been reported through the use of curettage, or some blunt dissection variation thereof, by several investigators. Hertz[3] has described a technique using a spoon-shaped instrument with applied manual pressure to remove these lesions. The verruca is separated out from the surrounding tissue bluntly and much caution is exercised to prevent exposure of the deeper adipose tissue. The use of parasine mesh and parathesin powder is then advocated for the immediate post-removal dressing. Overcast[4] has reported on the successful use of Gelfoam®[2] as a post-operative dressing following curetting of verrucoid lesions by blunt dissection. He feels the use of this material has effectively obviated the necessity of using sutures and has adequately controlled hemorrhagic consequences. Prazak[5] and Weinstock[6] have curetted plantar verrucae for several years with considerable success using a mastoid curette of optimal size to approach the lesion.

A report of an 18 month survey in the management of plantar verrucae via excision and curettage is offered in this paper. It has proven to be distinctly effective in the author's hands, and the high percentage of success attained has established it as the treatment of choice in the Podiatry Clinic at this hospital and in private practice.

Therapy with this procedure has been provided to military personnel, officers and enlisted men, and their dependents, as well as private patients. It has now been followed on 109 cases to date with a total of 207 verrucoid lesions. The ages of the patients have extended from 6 through 55 years. The duration of time that these lesions have been present prior to treatment has varied from 2 weeks to 8 years. The number of lesions removed at a single office visit has ranged from a solitary verruca to as many as 12 on one foot. The sizes encountered have averaged 1 mm. to 1½ cm. in diameter with varying depths and extent of tissue involvement. The locations of the lesions have been scattered about, involving subdigital and interdigital areas, plantar forefoot and heel weight bearing sites, as well as non-weight bearing sites and marginal border areas.

### Procedure

Local anesthesia is obtained through the use of 1 or 2% Aqueous Xylocaine,®[3] with or without epinephrine. This is the medication of choice although others will certainly suffice. A tibial nerve block at the medial malleolar ankle area with 1½ to 2 cc. of Xylocaine and/or direct tissue infiltration with smaller amounts using a tuberculin syringe and fine needle is accomplished. A dorsal approach through the interdigital web is preferred when the lesion is accessible thereby. The use of a topical skin spray preceding the needle entrance is often helpful. The sterile instruments employed are #3 scalpel with #11 blade, size 1 and/or 00 oval, spratt, mastoid curette, tissue forceps, and curved iris scissors plus an adequate light source.

The skin is prepared with suitable antiseptic solution and the overlying tylomatous excrescence when present is routinely reduced to reveal the aberrant tissue clearly and distinctly. The circumferential margin is incised in its entirety with the scalpel blade directed vertically to the skin surface along the line of cleavage until minimal

®[2] Upjohn

®[3] Astra

hemorrhage obscures the field. Lateral digital pressure is now utilized to provide visibility during the remainder of the procedure. The iris scissors is now used to snip overhanging marginal keratotic tissue along the skin surface as the mass proper is reflected by the forceps. A mastoid curette of desired size is then directed in a circular, fluctuating, rotary motion with firm pressure to undermine the lesion in depth. With diligent application the growth is removed en masse and in toto, with minimal fraying and shredding of the base and margins. A clean, smooth, glistening base remains after meticulous search is carried out to eliminate remaining bits of verrucous tissue clinging to the walls of the ulceration. This step is of prime importance. If performed precisely, the lesion all but shells itself out, completely intact and with little appreciable difficulty.

A sterile Gelfoam plug, slightly larger than the diameter of the lesion, is introduced into the cavity, followed by sterile, gauze plaques, and adhesive bandage. Immediate ambulation is employed to enhance hemostasis, and the patient is dismissed with proper instructions and medication.

Post-operative discomfort is usually minimal and is adequately controlled by rest, elevation, and APC's with or without codeine. This will vary with the depth, number, extent, and duration of the lesions. However, return to classes in 1 day for school children is the rule rather than the exception.

The dressing is maintained dry and intact for 2-3 days and is then easily removed without adherence to the clot provided for by the Gelfoam framework. The lesion is redressed with Tincture of Zephiran Chloride®[4] and a Bacitracin Ointment bandage is reapplied. It is continued dry and clean for approximately 5 days and no further therapy is usually necessary on this recall visit.

®[4] Winthrop

Healing is generally uneventful, rapid, and complete and is devoid of scar formation. No potential cautery or electrical currents are employed as it tends to prejudice rapid recovery, retards early ambulation, delays healing, and encourages scarification.

The patient is usually recalled in 1 month and then in 3 months for rechecks and complete reformation and restoration of the skin lines is noted with minimal evidence of the original lesion site. The Gelfoam aids in forming a scab-like eschar which eventually flakes off during this period of time.

### Discussion

The recurrence rate with this procedure has averaged 9% with approximately 91% successful elimination of the lesions on those cases followed for 3-5 months. These include several occasions where smaller, satellite lesions have been observed to disappear following effective therapy to the larger, nearby parental verrucae.

The regrowths, when present, have fallen into 2 categories by and large.

1. Keratotic plug type—not a true regrowth, which merely demands 1 or 2 occasions of routine, pain-free enucleation for complete success.
2. Superficial verrucous tissue type—necessitating further excision and curettage or other conventional therapy for elimination.

The explanation offered for these recurrences is felt to be based upon faulty technique employed and/or inaccurate diagnosis of the original lesion. Inadequate removal of fine verrucous tissue shreds within the ulcer from along the sides and base very likely accounts for most of the recurrences. And further, when the lesion is not correctly differentiated from borderline cases of neurofibrous helomata, regrowths tend to occur here again, in spite of the temporary symptomatic relief obtained following excision and curettage. It

is presumed that greater attention to technical detail and accurate differential diagnosis will substantially decrease the number of failures on initial visit cures encountered up to the present. However, further study will be needed along these lines.

The high degree of success, however, and the ease and simplicity of operation in the office, has made this procedure our favorite. In addition, reduced hemorrhage, notable absence of infection, minimal post-operative pain, immediate ambulation, minimal office visits, lack of scar formation, and rapid healing have all served to emphasize its distinct advantages over other methods.

### Summary and Conclusions

1. The preferred method of managing plantar verrucae in our office is presented.
2. Approximately 91% success on initial visits has been obtained generally.
3. Accurate diagnosis and selection of case-work plus careful technique should further enhance the gratifying response to date.
4. This procedure is offered to the medical and podiatry fraternities as further confirmation of the efficacy of the curettage method of approach.

*1087 Warwick Avenue*

### References


1. Steinberg, M.D.: *A New Treatment for Resistant Warts*, Surgery, 39: 642, 1956; *A New Treatment for Resistant Verrucae*, J.N.A.C., 44: 7: 17, July '54.
2. Du Vries, H. L.: *A New Approach to Intractable Verruca Plantaris (Plantar Wart)*, J.A.M.A., 152: 1202, July 25, 1953.
3. Hertz, Carl: as cited in Modern Foot Therapy, Gross, Reuben, H., 1948; Modern Foot Therapy Publishing Co., N. Y., pg. 240-242.
4. Overcast, V. C.: *Curetting Verrucae with Minimum Hemorrhage*, J.N.A.C., 47: 187-188, April 1957.
5. Prazak, G. and Thomas, D. E.: *Curettage Treatment of Plantar Warts*, Archives of Dermatology, 71: 122-123, Jan. 1955.
6. Weinstock, B. S.: *An Evaluation of the Curettage Treatment of Plantar Verrucae*, J.N.A.C., 47: 67-68, Feb. 1957.


## A "MISSING LINK" IN THE TREATMENT AND CONTROL OF EPIDERMOPHYTOSIS*

SIDNEY HIRSCHBERG, Pod.D.
Forest Hills, N. Y.

THE major problem in the management of epidermophytosis has been recurrence of the disease after an apparent response to treatment of choice. That there is a wide choice of medications effective in eliminating the clinical symptoms on the feet is evidenced by a recent study which revealed no less than 135[1] now being used by podiatrists and dermatologists. However, despite this vast armamentarium, recurrence has been the rule rather than the exception.

The literature reveals much evidence to substantiate the role played by infected footgear as one of the prime factors causing reinfection. Sutton and Sutton[2] state that fungi, like bacteria, breed speedily under suitable conditions. Animal and human sources of reinfection, along with inanimate sources such as clothing and shoes, must be recognized and dealt with.

It has been further stated that infected shoes and stockings should be discarded or disinfected.[3] Collens and Boas,[4] referring to treatment of ringworm of the feet, state that practical procedures to prevent reinfection include destruction of the fungi in shoes and stockings. This need is emphasized in the care of the diabetic foot.

Further evidence is added by Howell[5] on

* A report of investigations coordinating the results of a series of researches, laboratory tests and clinical studies by The American Foot Health Foundation. Paper submitted in the William J. Stickel Annual Awards for Research in Chiropody-Podiatry, 1958 and presented at the Annual Meeting of the A.P.A., Washington, D. C., August 1958.

onychomycosis when he states that if there is a recurrence it is most likely to be caused from reinfection, rather than insufficient treatment. Old shoes, he contends, should be discarded since it is difficult to completely remove the danger of reinfection from leather.

The significance of the problem is best summed up in a special project of the U. S. School of Aviation Medicine[6].

"The incidence of tinea pedis (Athlete's Foot) poses a major civilian and military problem. Infections of this type can become sufficiently severe to cause considerable loss of man hours and fighting strength.

"The number of cases of Tinea Pedis is much higher than commonly realized. Fox & Shields[7] have shown that more than 50% of all males in the U. S. at one time or another are infected by fungi causing athlete's foot.

"In some cases, present-day medication and methods of treatment of infection of tinea pedis are highly effective. However, as in the case of most fungus infections, treatment to a complete cure is a lengthy process even under ideal conditions. In many cases, treatment is further complicated by constant reinfection due to rewearing of contaminated shoes and stockings. Berberian[8] in 1938 showed that fungi remain viable in stockings after simple laundering. In a study of 100 patients with mild recurring dermatitis, Jameson and McCrea[9] recovered pathogenic fungi from 40% of the shoes, and organisms of doubtful pathogenesis from an additional 34%. These workers believed it was definitely shown that footwear does harbor pathogenic fungi, and may be a source of reinfection, as well as a source of primary infection. They advised the sterilization of footwear at intervals during the course of treatment.

"The most common methods in use at the present time for the sterilization of footwear consist of either immersion of the shoes in a weak solution of formaldehyde, or the pouring of the formaldehyde solution into the insole and storing the shoe in a tight box. These methods while comparatively simple leave much to be desired as the shoes must be thoroughly cleaned and treated with leather preservatives to protect their wearing qualities after sterilization.

"A gas that could penetrate all parts of the shoe, be harmless to the leather and require no post-sterilization treatment, would be ideal."

Following five years of intensive research, such a gas has been developed, which fills the apparent void in the treatment and control of epidermophytosis. Not only effective as a prophylactic but primarily as a supplement to professional treatment, this gas, by nature of its chemical composition, has overcome, by its simplicity of application, previous cumbersome and ineffective methods.

There were many chemical complications involved in the development of this gas into practical applicable form. These embraced, particularly the proper evolution of nascent vapors in addition to the active ingredients. In turn, this depended upon the degree of dispersion of the particles and the proper combination of pressure, temperature and the time cycle during processing.

This medication is finally available in tablet form on prescription. Called Zondex®[1] by the chemical engineers who developed the compound, it contains trioxymethelene and hexahydrothymol as active ingredients. The tablets come in hermetically sealed, plastic-lined aluminum pockets, in units of six. Accompanying each "sleeve" of tablets is a non-hydrostatic polyethylene bag.

These tablets, placed in the polyethylene bag with the shoes and hose of the patient, effectively destroy pathogenic microorgan-

®[1] Gross-Padow Corporation

isms in the footwear, generally recognized as a source of reinfection.

When a tablet is exposed to the air, the atmosphere moisture causes its components to react. The reaction produces the following:

A specific pH within the tablet which catalyzes the main reaction to release its vapor at a constant rate:

A. This causes the evolution of a vapor which permeates every crevice of the shoes and socks; the vapor is lethal to microorganisms in the leather and other shoe material. Tests[10] proved that a low concentration of fungicidal vapor remains in the footwear for months at a time. There is sufficient absorption of the fungicidal vapor by the leather and canvas of the shoes to render them permanently fungus-free for the life of the shoes.

B. Then it reacts with the protein in the leather and other shoe material, and in the fungus cell to saturate the amino complex, rendering the protein molecule insoluble.

C. Thus, the insoluble protein molecule is unavailable to the microorganism for its metabolism and the pathogenic colony expires for lack of nutrient. (See illustration)

No adverse effect on the color, size, strength, appearance or pliability of the leather and other shoe material has been reported. In fact, tests[11] have disclosed that treatment of the shoes with the tablets as prescribed, strangely enough, prolongs the life of the leather and other materials. In addition, a concomitant result is the eradication of all obnoxious odors from the shoes.

The prescribed instructions for use as a supplement to professional treatment of tinea pedis are simple. First the shoes and socks of the patient under treatment are placed in the plastic bag provided and three Zondex tablets are dropped into it. The top is gathered together and secured with a rubber band. The shoes, socks, and tablets are kept in the polyethylene bag overnight, and the patient is instructed to wear the shoes immediately after removal from the bag. No airing is required. This procedure is to be continued in accordance with the doctor's advice and supervision. Tests have shown it to be advisable that all the patient's footwear, including new footgear, should receive similar treatment.

Clinical and laboratory tests, of the Zondex tablets, conducted at the foot clinics of the New York College of Podiatry,[12] Temple University, School of Chiropody,[13] and by an independent firm of chemists,[14] produced the following findings indicating the effectiveness of this new adjunct to treatment:

(1) 95% of the patients' shoes tested before treatment contained spores of fungi. (M. albicans, T. gypseum, Aspergillus and T. purpureum most prevalent)

(2) After the same shoes were treated with this new tablet fumigant for 24 to 48 hours, *no* evidence of these spores could be found on re-examination.

(3) 72% of those patients with clinical symptoms of tinea pedis showed, on re-examination, a more rapid marked improvement or a complete recovery without recurrence to date, when their footgear was subjected to this new method of fumigation as a supplement to regular treatment.

(4) These tests also disclosed that the new fumigant was effective in the control of hyperhidrosis and bromidrosis.

(5) All the tests indicated a negligible incidence of skin sensitivity to the compound.

(6) Intensive tests[15] reveal too, that the vapor treatment is effective for two years after date of exposure. This indicates that a pair of shoes may be rendered free of pathogenic organisms

for the effective, useful life of the shoes.

It must be noted that continuing laboratory tests and chemical analysis disclose the possibility that leathers and other components of shoes, when exposed to the vapors, with new methods under development, may be rendered fungistatic *permanently*.

These investigations present evidence that a long felt need has been filled by an effective solution to the heretofore perplexing problem of recurrence in the treatment of epidermophytosis. By virtue of its ease of application, its proven performance in laboratory and clinic, the fumigation process by the Zondex technique places the vital missing link of a valuable supplemental adjunctive to treatment in the hands of the doctor.

This has special significance for the podiatrist as fungus infections are a frequent complication of most other foot problems. The feet of diabetic, peripheral vascular, and older patients, require special prophylactic and hygienic care. The feet of patients with "arch trouble" are easily susceptible to infection and reinfection, because they are overstrained. Feet under professional treatment should have this extra care to reduce the possibility of a complicating fungus infection.

This report is best summarized by the comment of one researcher[16] who stated, "Any hope for cure of epidermophytosis, bromidrosis and hyperhidrosis is doomed to failure unless the environment of the foot is controlled, and this form of supplemental treatment apparently fulfills that requirement.

*107-07 Continental Ave.*

## References


1. Survey on Pharmaceuticals: American Foot Health Foundation—1957.
2. Sutton and Sutton: *An Introduction to Dermatology*, 4th Ed. C. V. Mosby Co. Pub.
3. V. Pardo-Costello, M.D.: *Diseases of the Nails*, Charles C. Thomas Pub. 1941.
4. William S. Collens, M.D., Louis C. Boas, M.D.: *Helpful Hints to the Diabetic*, Charles C. Thomas, Pub. 1949.
5. H. W. Howell, D.S.C.: *Onychomycosis*, J.N.A.C., Vol. 47 No. 3, March 1957.
6. John D. Fulton, M.S.C., Roland Mitchel, Ph.D., Charles Morhouse, M.S.C.: *Sterilization of Footwear to Prevent Reinfection with Tinea Pedis*, Project No. 21-35-002, U.S.A.F. School of Aviation Medicine, Report No. 1-2 1951-52.
7. Fox, E. C., and T. L. Shields: *Resume of Skin Diseases Most Commonly Seen in General Practice*, J.A.M.A., 140: 763 (1949).
8. Berberian, D. A.: *Dermatophytosis of the Feet*, Arch Dermat. and Syph. 38: 367 (1938).
9. Jamieson, R. C. and A. McCrea: *Ringworm of Feet, Shoes and Slippers as a Source of Reinfections*, Final Report Arch. Dermat. and Syph. 44: 837 (1941).
10. Consulting Chemist—Report 1956.
11. Consulting Chemist—Report 1957.
12. New York College of Podiatry Foot Clinic, New York, N. Y.; Report 1957.
13. Temple University College of Chiropody Foot Clinic, Philadelphia, Pa.; Report 1957.
14. Skinner and Sherman, Inc., Chemists and Engineers, Boston, Mass.; Report 1957.
15. Consulting Chemist—Report on Study April 1956 to 1958.
16. S. Brezak, Pod.D.: Report 1957.

Detailed data on all reports, tests and studies cited above are available on request from the American Foot Health Foundation, Washington, D. C.


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Sixteen persons were killed in a train wreck because three words were left out of a dispatcher's order. Have you left out anything in your treatments that would have given your patient more comfort?

# CAPILLARY TUBE ACID APPLICATOR FOR VERRUCAE†

WILLIAM H. WOOLF, Lt. Cdr., M.S.C., U.S.N.R.*
Washington, D. C.

In the past twenty years the writer has run the gamut of technics in the treatment of plantar verrucae – potential cautery with acids, cryotherapy, curettage under local anesthesia, etc. In search of an efficient method of applying strong acid solutions to plantar verrucae, the writer first pursued a technic at the U. S. Naval Training Center, Bainbridge, Maryland which, further developed at the U. S. Naval Dispensary, Navy Department, Washington, D. C., has produced excellent results. The method allows for complete control of the acid employed in regard to quantity used, penetration into the tissues and application to the very marginal limits of the lesion. The following procedure is employed.

The writer prefers to use bichlorocetic acid (saturate solution) as a destructive agent. A mono-acid may be used in resistant cases by the author as it is found that the tri-acid is very frequently too weak.

The surface cornified layers of the verruca are first pared off with a scalpel as closely as possible, but with the production of little or no bleeding. Then instead of applying the strong acid solution to the surface of the lesion with the customary pointed wood applicator, a standard small glass coagulation capillary tube (75 mm. length x 1.0 mm. inside diameter) is employed.

The trichloracetic acid solution will rise inside the tiny tube by capillary action when the tip end of the tube is immersed in the bottle of acid. By observing the level of the liquid in the tube it is simple to determine how much of the acid is being used. The writer generally employs an acid column in the coagulation tube of about ¾" in height. A large drop of the solution may be noticed hanging at the very tip, or flowing down along the side, of the glass tube upon its withdrawal from the trichloracetic acid bottle. This should be wiped off with a quick stroke against a towel, paper or gauze sponge.

When a pointed wood applicator is used to apply acid to the skin, some of the acid is absorbed by both the wisp of cotton that may be wound about the applicator tip and also by the wood of the applicator itself. Some control in applying the acid to the tissues is thus lost. This absorption of acid cannot occur when using the glass capillary tube as the applicator.

Proceeding with the technic, the tip end of the tube is brought to bear against the surface of the verruca. On contact with the tissue a small amount of trichloracetic acid will leave the tube and moisten the surface of the lesion. As in the well-known manner of pricking the verruca with a pointed wood applicator, the capillary tube is repeatedly pressed against the wart tissue. As this procedure is pursued the acid will continue to emerge slowly and will be seen to settle lower and lower in the tube until it is completely spent. If it is desired to expel any or all of the acid from the tube, the tip end can be touched against a towel or gauze sponge. This maneuver will withdraw liquid from the tube in the manner of a blotter.

The repeated pricking of the lesion with the tip of the tiny glass tube will puncture the surface of the verruca and thus permit deeper penetration of the acid. Due to the rapid action of the trichloracetic acid, the

† This paper has been adopted from an original paper by the same author published in the July 1958 issue of the United States Armed Forces Medical Journal, "Use of Capillary Tubing for Applying Acid in Verruca Therapy." The author has provided a table of results and some additional information since the original publication.

*Podiatrist, U. S. Naval Dispensary, Navy Department, Washington, D. C.

disintegration of the tissue is readily observed during the application. The use of the capillary tube technic permits application of the acid to the very margins of any verruca regardless of configuration.

In some cases during the treatment, a pause of a minute or so in the procedure is desirable to allow destructive action in the tissues to proceed. After this momentary "wait," resumption of the pricking process for another minute, or half a minute, will produce greater amounts of destruction of involved tissue.

Some slight pain which may be experienced during the time of application will generally cease immediately upon termination of the actual pricking of the tissues. At worst, when considerable acid is applied at one sitting to cause rapid destruction of the growth, a stinging sensation may persist for an hour or so following treatment. This pain factor can be controlled by the practitioner, since he may apply only one or more capillary tube "doses" during the course of an application.

Following treatment, the verruca is covered with a dry dressing, usually a "band-aid," and the patient is advised to keep the lesion dry for the first day or two. The second treatment—curetting the devitalized tissue and reapplying the acid—is given usually eight to ten days later. If necessary, further treatment can be given after a similar time interval.

Generally, after a few treatments, the patient will state that the verruca is no longer painful. Upon examination the lesion will appear dehydrated and devitalized; the overlying tissue may be dark in color. The acid is usually not reapplied at this time and the patient should be scheduled for re-examination in two weeks. If after two weeks some wart tissue still remains, the verruca should be "touched up" again as the occasion demands. In the writer's experience only three or four applications of the trichloracetic acid have been required to eradicate most of the verrucae treated. Some cases have been cleared after only two applications and some after only one. In two of approximately thirty cases treated five applications of the acid were necessary for complete eradication.

The method of application described has been used successfully in the treatment of single, multiple and mosaic-type verruca. It has been employed not only in cases involving verrucae previously untreated, but it has also been used in those cases that have recurred following previous treatment. It appears to be a valuable technic for the treatment of the small satellite-type of wart which sometimes appears following surgical removal of a larger verruca. The method has not been attempted in those cases of verruca that have recurred following previous treatment by roentgen radiation.

During the procedure of pricking the verruca the clogging of the tiny capillary tube, caused by a "backing up" of some of the devitalized tissue, may occur. In such event the tube should be discarded for another or the clogged portion may be broken off by holding the clogged part of the tube between the folds of a 4" x 4" gauze sponge. After fracture the fresh end of the tube should be wiped clean with a stroke of the sponge.

Capillary tubes are stocked generally in two lengths, 75 mm. and 150 mm., packed 100 to a container. The cost is very nominal. Tubes 150 mm. (about 6"), or longer, may be broken to desired lengths.

The inside diameter "Lumen" of capillary tubes should measure approximately 1.0 to 1.25 mm. When it is desired to hold more acid in the tube a slightly wider diameter approximately 1.50 mm. may be used. If the lumen measures less than 1.0 mm. the capillary tube will become closed quickly with tissue.

TABLE I

| Age | Type | No. of Cases | No. of Treatments per case | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | 6 |
| 3- 7 | Single | 3 | 2 | 1 | | | | |
| 7-11 | Single | 9 | 5 | 1 | 3 | | | |
| | Multiple | 3 | 1 | 1 | 1 | | | |
| 12-16 | Single | 12 | 8 | 2 | 2 | | | |
| | Multiple | 5 | 2 | 1 | 1 | | 1 | |
| | Mosaic | 1 | | | | | | 1 |
| 17-21 | Single | 1 | 1 | | | | | |
| | Multiple | 6 | 1 | 3 | 2 | | | |
| over 21 | Single | 2 | 1 | 1 | | | | |
| | Multiple | 2 | | | 1 | 1 | | |
| | Mosaic | 1 | | 1 | | | | |
| Total | | 45 | 21 | 11 | 10 | 1 | 1 | 1 |

The tip end of a broken length of tube should always be wiped clean before use. Incidentally, the sharp end of a broken length of capillary tubing will more easily puncture the surface of the verruca, permitting better penetration of the acid. Under control of one skilled in the technic, this is a desirable feature.

Table I summarizes some of our results on the series of 45 cases. It is interesting to note that, as we would expect, over 85% of the cases were under 21 years of age. Slightly better than 71% (32 cases) required two or less treatments. Only 10 of the 18 cases of single verruca required more than one treatment and only 2 of those more than 2 treatments.

This technic may have value in other dermatological procedures. Variations of the technic and other effects will become apparent to operators.

Thanks and credit is given by the writer to Dr. Morton Kurzweil, Franklin Square, New York for the suggested trial of the capillary tube acid applicator.

*U. S. Naval Dispensary*

## CLINICALLY SPEAKING

*A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.*

### TALAR TILT FOLLOWING ANKLE INJURY

ROBERT KAHAN, Pod.D.*
Waterbury, Conn.

ANY injury of the ankle joint which we classify as a sprain, should be considered a self-reduced dislocation of the talus.

In a great majority of cases, routine A.P. and Lateral roentgen views are taken of the ankle mortise without regard for a possible rupture of the fibular collateral ligament with subsequent self-reduced dislocation of the talus. These misdiagnosed cases are treated as simple sprains, with the possibility of future disability often described as recurrent ankle sprain. The basic pathology is a chronic subluxation of the ankle joint.

In the simple sprain, there is stretching

* Podiatrist, Waterbury Hospital

and a few torn fibers of the fibular collateral ligament with stability maintained. The severe sprain, with the plantar flexion, inversion type of injury, presents an actual tear or avulsion of this ligament and the lateral capsule with resultant increased mobility of the talus.

The roentgen view taken to rule out astragular tilt is the A.P. view with the foot held in a forced inversion and plantar flexion. The diagnosis is then easy, for the astragular tilt is quite evident in these cases. The talus will be rotated on its axis. At times the positioning of the foot may be painful, due to localized edema. In these cases a sural or peroneal nerve block is recommended.[1] In holding the foot in this position, the operator may do so manually or with the aid of a belt or "stirrup."

### Anatomy

There are three components[2] of the fibular collateral ligament, anterior talo-fibular, calcaneo--fibular, and the posterior talo-fibular. The anterior talo-fibular ligament is the shortest of the three. It extends from the anterior border of the lateral malleolus to the neck of the talus. The calcaneo-fibular ligament, the longest of the three, is the only one which is extra capsular and extends from the tip of the fibula downward and slightly backward to the colliculus on the lateral surface of the os calcis. The posterior talo-fibular ligament, the shortest, extends from the digital fossa of the fibula to the lateral tubercle on the posterior aspect of the talus immediately lateral to the Flexor Hallucis groove.

The anterior and posterior capsule is thin, joining the tibia and talus, the lateral capsule is thickened and found between the anterior talo-fibular and the lateral talo-calcaneal ligaments, blending with them. It extends from the lateral border of the talus to the medial surface of the lateral malleolus.

### Pathology

Among authors there is variance as to which ligaments are torn in these cases. Bonnin[3] believes that the calcaneo-fibular is the first and easiest to rupture and further strain results in tearing of the lateral capsule and anterior tibio-fibular ligament.

Anderson and Le Cocq[4] believe that the primary injury is a tearing of the anterior talo-fibular ligament. They claim that a tear of the anterior talo-fibular allows anterior displacement of the talus in the ankle mortise in the coronal plane and rotational displacement of the talus medially on its vertical axis and when there is an associated tear of the lateral capsule, roentgen study will reveal the talus tilted as much as seven degrees. When both the anterior talo-fibular and calcaneo-fibular ligaments are torn, the talus may rotate 12-30 degrees. When all three are involved, complete instability occurs.

### Treatment

The treatment of cases where an astragular tilt is a component is complete immobilization in a short leg (from the foot to below the knee) plaster cast. Where there is complete instability, operative procedure on the ankle joint is indicated.[5] Cases of chronic and recurrent ankle sprain can be conservatively treated with a reverse Thomas heel with a 1/8 to 3/16 lateral wedge.

### Summary

The factor of talar tilt in ankle injuries is stressed. The necessity of taking roentgen views of the ankle in the forced inverted position is recommended. These cases are often treated as simple sprains and therefore not adequately. We should be more aware of this condition, looking for it in all ankle injuries. Treatment should be instituted when our services will assure a good result, or referred to the proper specialist where more radical procedures are indicated. With proper diagnosis and treatment, the incidence of chronic ankle instability can be reduced.

*60 Cooke Street*

*(Continued on page A25)*

# JOURNAL
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## PRESIDENT'S PAGE

May we all look up and forward! Let us resolve at the beginning of this New Year to cease allowing a very few individuals to create seeds of doubt and cloud the issues with trivia. Factual answers to any questions you may have are available to all for the asking. I want to assure you that the adoption of our new organizational name was not brought about by ulterior motives.

There is no question in anyone's mind that we need and desire unity and that we are too few in numbers. There is general assent to these facts. If you agree, then it must follow that those who would divide us by starting a new organization for our profession based on degrees have a narrow perspective, to say the least. We urge you to ask any and all questions you wish, but do not divide your energy and money on another organization weakening your national efforts.

Every man on the Executive Council and every committee chairman is doing his very best for you! And he is doing it at a personal sacrifice of time and energy. Have faith in these men whom you have elected. As president, I would like to say it is a privilege to work with such dedicated men.

We are making progress in many areas on a national level. For the first time, by invitation, we are participating as we should, in conferences concerning health and education problems of America.

I have much more to say but not on the President's Page.

G. E. Guenzler, D.S.C.

## FUND FOR THE ADVANCEMENT OF PODIATRY-CHIROPODY EDUCATION

On page 36 is a very excellent and significant report by Dr. Horowitz of the "Fund." The continued growth of our profession and our ability to fill the very important need of superior foot health service for the nation, demands that we raise five million dollars by 1965. We must give this support to our schools, through the "Fund" or directly to the schools. Your tax deductible contribution or pledge can be mailed in the special envelope included in this issue between pages 34 and 35.

## NEWS RELEASES

Because we have been busy building a profession, very little time, effort or money has been devoted to educating and informing the general public about the importance of foot health care, the advancements being made in our science, and to whom the public must turn for this information and service. As a result, a vast void exists in the public mind. Our local, state and national organizations must supply the information to fill the void and supplant misinformation.

The simplest and also probably the best way to accomplish this is through specially prepared releases directed to the mass communications media of newspapers, periodicals and radio-TV. Obviously, the ideal is to retain professional people specially trained in this field. But even in the face of limited budgets, local and state Public Information Committees of members can get some of the "hang-of-it" by reading science reports and articles in newspapers and magazines, and can stimulate writers through carefully arranged interviews.

At the national level releases are prepared regarding the papers that are presented and the events that transpire at our Annual Meeting. Monthly, releases are sent out to hometowns of authors of articles that are published in the *Journal*. And, of course, special events provide good material for releases. We also have made efforts to be known as a source for information about feet and as a consequence are filling more and more requests by writers.

In the past 18 months, our clipping service has sent us almost 1400 clippings. This, we are told, probably represents only one-half of the actual number of newspaper mentions. And this has been accomplished on a "shoe-string" budget.

Because of our present dual professional designation we sometimes hear from our members about items in their newspapers to which they raise objection. Our releases are carefully checked to insure adherence to dual terminology. However, editors and their staffs exercise their editorial prerogatives and publish what they believe their readers want. This means that frequently one term or the other is deleted; and for some reason the term chiropody is most frequently omitted in "chiropody states," judging by letter volume. On the other hand, some "chiropody" states (and regions) have issued releases that are published in "podiatry" states and these releases did not contain the term "podiatry."

Both of the above types of items in the press produce irritation. We suggest that this irritation be made an opportunity. When the press reports in a manner at variance with your viewpoint, your Public Information or other Officer should direct a dignified, temperate and carefully worded letter to the editor. This is an opportunity to turn that with which we do not agree with to our advantage and obtain "double exposure" for public education.

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## ANNUAL DIRECTORY

An addendum sheet to the 1958 Annual Directory is provided on pages A29 and 30 of this issue. This sheet contains corrections of errors in the Directory and new members joining between the time of publication of the Directory and December 10.

We suggest you check the address on your *Journal* envelope to assure accuracy in the 1959 Directory.

## WASHINGTON REPORT

For the fiscal year 1958 the National Institute of Health has awarded, through the Public Health Service, almost 100 million dollars in research grants to non-Federal institutions with over 6 million dollars going to fellowship grants.

An attempt will be made to have the Federal Government help defray the deficit cost of medical education. The Association of American Medical Colleges will initiate a one year study of costs of medical education and present the data to congressional committees.

Health bills in the 86th Congress are expected to be the highest in the history of this government. Foremost will be government sponsored catastrophe insurance plans which could put the government into the insurance business. The increase in number of retired voters is of interest to both political parties and in order to obtain their votes the candidates are promising health care, where it is most needed, in old age.

### Social Security

A reminder to all members that on January 1, 1959, the new Social Security taxes go into effect. The new rate for employers and employees is 2½% on income up to $4800.00, or a maximum of $120 per year. For self-employed persons earning a minimum of $4800.00, the Social Security tax will be $180.

Under the new law, benefits will be boosted by an average of 7%.

### Jenkins-Keogh Bill

Introduced in the 85th Congress, this bill passed overwhelmingly in the House, only to be defeated on a technicality in the Senate. The Jenkins-Keogh Bill, if passed, would have permitted the self-employed to set aside a portion of his income into certain government bonds and other insurance plans to be used for retirement purposes. The income would not be taxable until used in later years or upon death.

The American Thrift Assembly, an organization representing the self-employed, in which the American Podiatry Association is a member, has asked that all interested members seek out the political victors of this year's congressional election and impress upon them that the passage of legislation such as the Jenkins-Keogh Bill would be a stabilizer in the future economy of our nation. Here the self-employed can prepare himself for a sound financial retirement plan without burdening the government agencies for care. The income and capital of the sums deferred become taxable during the retired years of the self-employed, permitting income to the government at that period.

This is not tax exemption, but tax deferment, and acts as an equalizer of the highest and lowest levels of the self-employed's productive capacities. It also affords him the same privileges now enjoyed by corporation employees, where similar retirement income plans are permitted.

The American Podiatry Association requests that its members contact or write their congressional representatives asking for support of the Jenkins-Keogh Bill, or similar legislation that may be introduced in the new 86th Congress.

### Shoe Labeling

Considerable interest has been evoked in Congress by the complaints of parents who purchase so-called "all leather" shoes only to find, when repairs are required, that the shoes are beyond repair because of the cardboard and paper that has been substituted by the manufacturer.

The result is that a "Shoe Labeling Law" administered by the Federal Trade Com-

mission may be introduced in the Senate when the 86th Congress convenes. Sponsors of the bill will probably be Senators Porter of Michigan and Morse and Neuberger of Washington.

The first task facing the new Congress as it reconvenes this month will be the reshuffling of the various committees as a result of the recent elections. In general, matters for legislative consideration will make 1959 a year of preparation for the Presidential election year of 1960. Prominent consideration will be given to bills pertaining to taxes, health and education.

With the success of organized labor in the recent elections, there will be a definite attempt to press Congress for the passage of the Forand Bill which will provide free hospitalization and surgical care for beneficiaries of social security. Probably cosponsoring the bill will be Representative Dingell (D. Washington) who may introduce his own bill for compulsory national health insurance.

### Standardized Fees for Medical Services Proposed

In anticipation of hearings, expected sometime in February, by Senator Morse (D. of Oregon), on the cost of medical care in the District of Columbia, the local Medical Society, backed by the A.M.A., is rushing to completion a plan to assign a definite unit value to each medical procedure.

The plan, receiving much opposition from conservative members, is supported enthusiastically by the more liberal elements and would assign one unit to an office visit. For example, four dollars and thirty units for an appendectomy, the fee for which would be $120. Similar plans are already in operation in California, Kansas and Iowa. The A.M.A., however, only recently endorsed such plans when the House of Delegates met in Minneapolis.

Acceptance of the plan would mean that doctors would be standardizing their fees themselves in anticipation of future moves by the Federal Government to do this through compulsory health insurance.

### Social Security Favored by Polls Of Medical Societies

Ohio and District of Columbia physicians were recently polled and indicated by 2 to 1 a preference for participation in the Social Security program. It is predicted that within 18 months, the A.M.A. will ask for inclusion, or at least be receptive to coverage.

### Federal Workers Prepaid Health Insurance

Various unions, including the American Federation of Government Employees, during 1959 will demand enactment of legislation to cover medical care insurance for some five million Federal workers and dependents. Present plans call for the government to pay full premium for major medical, or catastrophic, expense coverage and assume at least 50 per cent of the cost of basic health insurance, including hospitalization benefits. The Administration, although undecided at present, may ask Congress to provide this fringe benefit program.

### Multiple Sclerosis Pamphlet Available

U. S. Public Health Service will mail single copies, without charge, of their new publication, "Multiple Sclerosis: Hope Through Research." Address requests to the National Institute of Neurological Diseases and Blindness, Bethesda 14, Maryland. Latest developments in early diagnosis and certain therapeutic procedures are described.

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Experiment is the only road to truth.
*Vines (Spanish scientist)*

## PUBLIC EDUCATION INFORMATION

*From time to time the A.P.A. headquarters has received requests for sample lectures for public education purposes. We have also been asked for recommended instructions for foot care for the patient with diabetes and for patients with impaired circulation. We hope this group of three papers will serve a useful purpose.*

# NURSING HOME FOOT PROBLEMS AND THE GERIATRIC PATIENT*

LAWRENCE A. FROST, D.S.C., F.A.C.F.S.
Monroe, Michigan

Foot care of the senescent or prematurely senile patient, or podogeriatrics as we chiropodists would designate it, is one of the more difficult problems we have to face. Challenging as their problems may be, the major object is to prevent infection and a resultant gangrene.

There is no question that feet are the danger point for the aged. To neglect or mistreat them can result in serious setbacks. Because of the slowness of healing and the danger of infection in the poorly nourished tissues, any blister, bruise, abrasion or cut on the skin should be the cause for concern. This should be so particularly with diabetics. Proper foot care is so important that every major hospital in the country recommends that diabetics see a foot specialist (podiatrist-chiropodist) regularly—at least once a month.

Most aged patients have chronic, progressive or degenerative disorders. In my comments today we will not, for lack of time, cover the problem confronting you in the care of the patient admitted with a foot disability, but will emphasize the general prophylactic and hygienic foot care of your patients.

There are three reasons why this last is of great importance to you. Routine prophylaxis of all of your patients is highly important because: (1) it increases the comfort of your patients. (2) it lessens the possibility of requiring additional chiropody-podiatry, medical or surgical care, (3) it reduces the cost of nursing care, keeping down your overhead, and in turn, provides a saving to the patient.

If you can keep your patients comfortable while they are with you; if you can prevent a loss of limb; if you can help prevent them from vegetating by keeping their feet in shape so they can get around more easily, they can be motivated to do other things including those leading to better health.

Most degenerative disorders affecting the lower extremities are those relating to the circulatory system. Gangrene is the dreaded word in this field. Starting, as it usually does, with a small beginning such as a blister, the loss of a foot, leg or life may be imminent. That most gangrene can be prevented is a well-known fact in our profession, and has been demonstrated in the chiropody-podiatry service in diabetic or vascular disease departments of large hospitals all over the country. A typical example is that of Cincinnati (Ohio) General Hospital where some 14 chiropodists under Dr. Rex Hawkins, chiropodist in charge, participate in the extremity care of the diabetic and vascular disease patients. When they first began their service, amputations ran between 22 and 24 each month. In a period of 12 years they played the leading role in decreasing amputations to between two and four each month. In similar hospital clinics around the country where a chiropodist is on the service, amputations have decreased as much as 68%.

* Delivered May 14 at the Tenth Annual Convention of the Michigan Nursing Home Association, Fort Shelby Hotel, Detroit, Michigan.

I think it would be well to discuss some of the recommended procedures for special care of the extremities. I realize that the majority of your patients are partially or completely bedridden, therefore the remarks that follow must of necessity apply only where feasible and where the attending doctor has not prescribed other procedures for his patient. All of the suggestions are intended to be preventative.

Every effort should be made to prevent all forms of mechanical, chemical or thermal injury.

Mechanical injury may vary from a bruise on a bed rail to a minute scratch from the nail clippers. The nursing staff constantly must be aware of the patient's impoverished circulation and inability to heal or resist infection. Momentary thoughtlessness could lead to disaster.

Avoid tight or ill-fitting shoes, wrinkled hose or circular garters on your ambulatory patients. Soft leathers such as kid are advised. Fleece lined slippers are recommended to keep the feet warm while sitting around.

Strong antiseptics and germicides, such as tincture of iodine, should be avoided as they tend to destroy the skin and could start an ulceration. Alcohol and witch hazel are always safe though they tend to dry the skin. Skin dryness can be alleviated by the frequent application of lanolin. It is advisable to apply lanolin to the entire foot (please include the nails) of all patients regularly. Application daily, following a foot bath of soapy warm water, and with a light massage, will control the skin dryness of the senescent patient. This dry skin is the source of a great portion of your problems in the lower extremities. The dry skin cracks or callouses easily, and in turn becomes infected easily. We forget too that the act of walking grinds dirt and bacteria into the skin. Knowledge of this is the reason for the foot surgeon's extreme care in the preparation of the skin before foot surgery. The skin is the first line of defense against infection. Every effort should be made toward keeping the skin soft, pliant, clean and whole.

The daily washing of the skin in warm, not hot, water using a mild soap and a wash cloth or soft nail brush is advised. Dry the skin by blotting with a towel, especially between the toes. Is there any reason why the skin of the feet should not be given care at least equal to that of the hands? Lack of skin care is one of the cardinal reasons for the high incidence of gangrene in the lower extremities.

Following the foot bath the ankles and toes should be worked or limbered up voluntarily. That is, get the patient to rotate the ankle; then flex and extend it as well as the toes. Then this should be done manually by the nurse. The skin and nails can be lightly coated with lanolin, applying it with light massage. If the nails need cutting, cut them straight across, then file the edges so they will not scratch the other foot. Do not attempt to cut into the corners or use instruments under the nail edge other than an applicator dipped into alcohol.

At this point it is well to mention that there is no one rest position that is advisable for the feet of all bed patients, particularly if they have some lesion on the foot. If the foot is at bed level and maintains a dusky hue the foot is too low. If it is elevated too high it may become pallid indicating an anemia of the tissues, and could interfere with healing. In some instances it will cause pain. If, in placing the foot on one pillow, or elevating the foot of the bed to an equivalent height the skin retains a normal color, you have a satisfactory elevation. After reasonable adjustment, if the foot remains either white or bluish, consult the physician or chiropodist.

The patient complaining of cold feet or whose skin temperature is low can be

aided with the use of bed socks. Under no circumstances use a heating pad, hot water bottle or hot soaks. These old folks have a lessened sensibility to heat, therefore cannot give you an accurate account. Do not accept their statement that their feet are warm for they have decreased sensibilities to heat and cold. I have seen blisters arise from the use of a hot water bottle that would not harm any of us. This can be fatal to the patient; and what a reflection on your institution after you have gone to such great efforts to establish a fine reputation.

Make it a rule to examine the entire foot of each patient each day. If there are any blemishes, discolorations, abrasions, blisters, fissures, swelling or complaint of discomfort, report it to the physician in charge or to the chiropodist or foot specialist. Watch particularly for redness or discoloration around the nails, ends of the toes, or on the heels. Much discomfort, concern and expense can be avoided by this inspection.

And now I should insert a few remarks that should give some comfort to those who would dispense all the service necessary to make this program a success—the nurses and their aids. They are the ones who will do the hand and foot work in a routine of this kind and, to operate at peak efficiency and patience, they must have foot health.

The nursing profession abounds with foot problems, a share of which result from improper or ill-fitting shoes. The very act of lifting or shifting a patient requires good footing and balance, both demanding a well-fitting oxford of low heel and soft leather upper, preferably of kid leather. If you cannot wear a low flat heel, a wedgy sole is advised though not absolutely necessary if the shank or arch is rigid. Where the rest home or nursing home flooring is terrazzo or tile covered concrete, crepe soles are advised to provide shock absorption. Avoid cushion insoles for they draw, cause excessive perspiration, and frequently aggravate foot imbalances. Wear fully lined shoes. Keep the heels of your shoes straight. Don't have your shoes resoled.

If you must wear nylon hose wear those that have cotton feet to aid in the absorption of perspiration.

At the end of each day of duty, wash your feet in warm water using a bland soap. Rinse in cold or cool water then apply alcohol or witch hazel after blotting the skin dry. If your feet tend to swell, elevate them for at least a half hour. If they persist in swelling after elevation; if they are the source of continuous or repeated discomfort, you need the skill of a foot specialist. You'll get but one pair of feet in your lifetime so be kind to them if you want them to be kind to you.

*Kresge Building*

### References


1. Friedman, B. E., and Sabia, M. L.: *Podogeriatrics,* J.A.P.A., 74: 3: 117, 1957.
2. Hawkins, R.: *Care of the Extremities in Diabetic Patients,* J.N.A.C., 43: 10: 30, 1953
3. Hawkins, R.: Personal communication.
4. Levy, R.: *Instructions for Foot Care of Patients with Diabetes and/or Impaired Circulation,* Beverly Hills Medical Clinic.
5. Rubin, A.: Personal communication.


## INFORMATION FOR A HEALTH EDUCATION DEPARTMENT STAFF*


NELSON E. GIDCUMB, D.S.C.
San Diego, Calif.


Dr. Wetherill, and staff of the San Diego schools' Health Education Department, I deeply appreciate your invitation to talk to you on foot health. When I first approached Dr. Wetherill, it was suggested I talk to this group on my profession, its educational background, growth and development of the foot, and describe some of the children's foot conditions to look for in the schools. At first this appeared not to be a

* Delivered before meeting of the Health and Education Department of the San Diego public schools.

Herculean task, but where does one begin in the description of one's professional functions.

The concept of the functions of chiropody, which is held by certain persons, even by those closely connected to medical circles, is a limited one. To some, the practice of chiropody is essentially treatment of corns and callus, to others it is the correction of gait disorders, to others surgical treatments of foot disorders. It is these and more. It is the diagnosis, treatment, and prevention of foot disorders from birth to death by the use of all the medical and chiropodical knowledge and technics that the healing arts possess.

Our scope of practice and the constantly increasing amounts of information demanded in the health fields has increasingly higher educational requirements. In chiropody, our education requirements have changed in the last 50 years from a 6 months' course to a 2 years' preparatory course in an accredited college of Arts and Science followed by a 4-year course of instruction in a chiropody college. The California College of Chiropody, located in San Francisco, is accredited by the Department of Education of the State of California and the Council on Education of the American Podiatry Association.

The Chiropody College curriculum and Clinic consists of 4,700 hours and includes courses in anatomy, physiology, materia medica, bio-chemistry, therapeutics and related subjects.

Special attention is paid to foot orthopedics and surgery, roentgenology and diagnosis. After graduation from college the chiropodist must pass a State Board Examination before he is licensed by the Board of Medical Examiners.

The old adage that the more knowledge and education one possesses on a subject the less one knows about it, seems to hold true in chiropody. The more adult foot disabilities the chiropodist treats, the more he comes to realize that an understanding of the child's foot is often essential to effective treatment of adult foot disorders.

Life is a series of growth and developmental processes. The untreated mild foot problem and developmental defect in childhood and adolescence will be the major foot disorder of the adult.

Growth and development are not the same. By growth we refer to multiplication of cells with increased number or size of tissue units. Development, on the other hand, is that process which leads to differentiation into specialized functional tissues and occurs concurrently with growth. We say a bone grows but a skeleton develops.

Development of the foot is usually divided into stages.

1. The infant, or pre-walking stage from birth to 15 months.
2. The child, 15 months to 8 years.
3. The adolescent, 8 years to 18.
4. The adult, 18 to death.

The infant's foot at birth is soft and elastic, and has the appearance of being wide and fat which causes the foot to appear as having no arch. The average foot at birth is 3 to 3½ inches long. The infant has the ability to kick and twist and wiggle his toes. Later, about three months, he will lose the elastic characteristics of the newborn. It is during this time that muscular contractions develop and disturbance of the bone and joint become evident with an abnormal positioning of the child's foot or leg. It is recommended that all children's feet be examined between 3 and 6 months of age, as well as those of the parents, in order that inherited dominant foot characteristics of the parents may not be passed to the newborn. These abnormal developmental conditions respond readily to treatment begun at this age. After 6 months, treatment must be classified as late and response is slower.

Later the infant crawls and in this stage he develops his muscles and ligaments that

will be used when standing and walking. As this is a period of rapid growth (300 per cent the first year) no constriction, such as shoes, tight bed clothing, too many diapers or other articles should interfere with the development of the muscular, ligamentous or skeletal systems.

Between the ages of 9 to 15 months, the foot grows 25%, the child begins to walk. The child should do this voluntarily. At first he will walk for a short distance with a waddling gait. The legs are wide apart and he falls frequently. There may be a slightly flattened appearance to the foot, but as the child becomes more adept at walking the fatty pad over the longitudinal arch is absorbed and the foot takes on a new appearance with the formation of an arch. This arch may not appear and the foot will remain pronated (an inward rolling of the foot). This places an abnormal stress on ligaments and muscles which result in a malfunctional imbalance in the adolescent and adult.

At five years of age the foot will have developed into the appearance of the adult foot. The limbs are straight, there should be no in-toeing or out-toeing.

As I stated earlier, growth and development are not the same. During these early developmental years the growth centers of the bones have made their appearance and at various chronological times will begin their union into different bones to make the adult skeleton. This is an important point because it is most useful in determining the physiological age of a child. By comparison of the actual age to the bone age, endocrine and nutritional dysfunctions may become evident. For example, the bone ossification time in severe hypothyroidism will be delayed. This can be determined by x-raying the ossification centers of the foot.

The alterations in growth and development can take on many forms in the school child. The school nurse and teacher should look for the following symptoms, that may indicate a foot disorder. Don't expect the child to tell you he has foot trouble.

1. Poor posture and abnormal curvature of the spine.
2. Fatigue
3. Ankles which turn easily.
4. Peculiar gait.
5. Back leg and foot pains.
6. Stockings always damp.
7. No shoe seems to fit.
8. Abnormal shoe wear.
9. Repeated fungus infections.
10. Contraction of the toes.
11. Growths on the foot.
12. Repeated injuries on school grounds.
13. Physical activity and mental development impaired.
14. Poor or unusually good appetite.

Some of the common conditions in our school are:

I. Pronation of the foot or the so-called flat foot.

At first this condition appears on weight bearing, the child complains of pain in the arch, especially when wearing new shoes. The child has a bulge at the inner side of the foot. The knees are displaced inward, the child may complain of leg pains. Warm foot soaks to relax the muscles give relief, but treatment must be directed to reestablish lost muscle function by exercise, proper footgear, and realignment of the bony architectural pattern of the foot. It is this condition which leads to posture complex symptoms in adults. The inward rolling foot will cause ankle, knee, and hip and spinal articular changes. This will lead to traumatic arthritides that manifest themselves in the back and lower extremities.

The condition of pronation must be differentiated from the low arch. A low arch will give many of the same symptoms, however, the heel cord will not be short. The heels of the shoes will not run over. The treatment of the foot with a low arch is directed towards proper fitting of the

shoe with avoidance of any type of supportive structure. The painful foot in this condition is due to the constant irritation of the shoe pushing against the muscles bellies of the arch. The low arch is not a pathological condition, but is a foot type.

II. Gait disorders.

Gait in the child should be carefully studied because in-toe or out-toe gaits are weakening to the muscles and bone development, and usually are associated with a short calf muscle or poor arch positions. These require chiropodical care. Gait, it must be remembered, is an individual thing and wide variations are possible. If there is any question that a child has a pathological gait, the child should be examined as soon as possible.

III. Limp.

Limping is a common complaint. The child should be examined by a chiropodist so that he may rule out common reasons, such as improper shoes, foot injuries or foreign bodies. A limp may be the first symptom of an acquired skeletal disorder or disease as osteochondritis or bone necrosis. The heel bone at the age of 8 to 10 years in the girl and 10 to 12 in the boy may be the site of pain, especially when walking, jumping or exercising. The boy or girl may come to the nurse complaining of heel pain after gym classes or after jumping rope. He complains of having pins and needles in his heel. This condition, apophysitis, is due to an abnormal growth center in the heel bone. In these cases x-ray examination and routine lab work-ups are essential to properly diagnose and treat these disorders.

IV. Ingrown toe nails.

There are many conditions of the nail which are called ingrown nail. Among these are sunken nail beds, improper cutting of the nail and congenital malformation of the nail. All of these may give rise to the so-called ingrown nail. I'm sure you know the nails are to be cut straight across.

V. Verrucae.

I would like to mention papilloma or verrucae, commonly called warts. Surveys, conducted by the chiropodists, indicate that these are of infectious nature and may reach epidemic portion in a school. Recently virus-like particles in definite crystalline arrangement have been demonstrated in electron micrographs of suspensions of materials obtained from human warts. The nurse should be suspicious if the child complains of a flat scar-like lesion that causes severe pain. New and up-to-date treatment developed by the chiropodist gives much promise in the alleviation of this condition.

The foremost common condition in the schools is improperly fitted shoes. Numerous foot health surveys have been conducted in Connecticut, Pennsylvania, Arizona and Illinois. It is worthy of special attention that more than 1/3 of the children examined were wearing improper shoes. What is the correct shoe? The correct shoe must depend on the foot type: is the foot broad, narrow, low arch or high arch, the length of the toes, the length of the heel to the big toe joint, all must be considered in the correct shoe. The shoe must also help the foot to carry out its functions of locomotion, support, and as a shock absorber. The sole should be of leather or neolite with a semi-soft rubber heel.

These surveys point out another important fact—foot health education in children is of vital concern. If we can prevent a physical handicap in the child's foot, we can help the adult live his or her life more gracefully.

As in other fields of preventive medicine, the education systems of our country can be the answer to the problem of foot health in the child. We in chiropody hope that in the near future Health Education Departments will establish foot health educational programs and consult with the

chiropodist so that school authorities, and chiropodists can take steps to prevent foot problems in the child and adult.

*951 Eighth Avenue*


### References

1. Crocker: Public Speaking for College Students.
2. Ciba Clinical Symposia, Vol. 3, No. 6, Sept. 1951.
3. Dickson and Diveley: Functional Disorders of the Foot.
4. Hauser: Diseases of the Foot.
5. Lewis: Chiropodical Pediatrics.
6. Mayers: Physical Diagnosis.
7. Harrison: Principals of Internal Medicine.
8. Diehl: Healthful Living.
9. Morton: The Human Foot.
10. Luck: Bone and Joint Diseases.
11. Lewin: The Foot and Ankle.
12. Herman Tax, D.S.C.: Lecture, Los Angeles, Calif.


## FOOT CARE FOR THE PATIENT WITH DIABETES AND/OR IMPAIRED CIRCULATION*


SHERWIN E. LEVY, D.S.C.†
Los Angeles, Calif.


### Instructions to the Patient

PATIENTS with diabetes and/or impaired circulation will live longer, more happily and more efficiently if they will learn to take care of their feet.

The foot complications in these conditions may range from a simple irritation or corn to an unusually painful ulceration which, if untreated, may terminate in gangrene with loss of some part, or all, of the foot or leg, or even more disastrous results. Knowledge of proper foot care can greatly reduce the incidence of serious lower extremity complications such as ulcers, gangrene, or loss of limb. It is with this in mind that this bulletin has been made available to you. For your own benefit, read and learn the instructions outlined. If there is something within this bulletin you do not understand, your physician or chiropodist will be happy to explain it to you.

Your feet now assume a new importance. A simple irritation, bruise, or injury to the foot of most people usually heals quickly and without complications. That same irritation, bruise, or injury to the patient with diabetes and/or impaired circulation, may lead to a complicated situation wherein you may suffer pain, loss of time from work, and prolonged and extensive care. These consequences may well be prevented by observance of the following instructions.

### What You Should Know When Purchasing Shoes

Proper Shoes: Should be made of leather. Should be roomy across the toes, with a thumb's width from the end of the toe to the end of the shoe. Should be a blucher tie. (Overlapping tie) Should have a leather sole and rubber heel. Should fit snug in the heel and through the waist of the foot. Should be roomy across the ball of the foot. Should have a soft pliable upper. Should have hard toe cap to safeguard against stubbing injury or injury from falling objects. Should always be lined. A good quality cotton cloth is preferred.

### Some "Don'ts" About Your Shoes

Don't wear a shoe without using a mild foot powder inside, such as plain talcum powder. This dissipates moisture and prevents shoes from grabbing, and thereby reduces friction and irritation to the skin.

Don't work in bedroom slippers. Wear them only for the purpose for which they were made. Use them only when retiring at night and arising in the morning.

Don't work in style or casual shoes. They do not afford either sufficient support or protection, and put the foot in an abnormal position which causes strain, corns, callouses, blisters, etc.

* Compiled for use in the Nurses' Manual for the University of California, Los Angeles, California. Similar brochures were prepared by the author for the Veterans Administration Center, Los Angeles, California, and the Beverly Hills Medical Clinic.

† The author acknowledges that material for this was taken in large part from the pamphlet "Care of Diabetic Feet" compiled by the Nebraska Association of Chiropodists.

Don't wear rubber boots, tennis shoes or canvas shoes, with rubber soles, shoes made of patent leather, hard calf, reptile or plastics. Such materials are too harsh, prevent evaporation or heat the foot.

Don't wear cut-out shoes or so-called sandals. Openings or straps may cut or blister; also, they do not afford proper support or protection. They are dangerous in case of spilled hot liquids, exposure to the sun, exposure to the heat or cold, or falling objects.

Don't wear new shoes over two hours per day for the first week. Check feet after each two-hour period for red spots, irritation, or blisters.

Don't neglect to examine the inside of your shoes to see if the insoles have become bumpy or cracked, the lining torn or wrinkled, or otherwise damaged.

Don't neglect to change shoes often, giving them a chance to dry out.

Remember, it is the fit of the shoe, not the price you pay for it, that denotes its merit. Needless to say, a good shoe, well fitted, is to be desired. The chiropodist will be more than glad to advise you on proper footgear. If you are doubtful about the shoes you now have, ask him to inspect them, and he will advise you whether or not they are adequate for your needs.

*Never* wear shoes without socks.

Heavy, good quality, preshrunk, soft cotton, cotton and wool mixed, or all wool socks are preferred. Thin socks do not afford enough protection.

Darns and holes should be avoided since they may lead to the development of blisters, and a simple blister may become a complicated infection.

Socks should be changed daily and carefully washed, followed by thorough rinsing to remove all soap.

Elastic top or tight socks should be avoided.

Elastic garters should never be worn.

Consult your shoe merchant about your sock size. He has a measuring device and chart to find your correct size. Socks too large cause blisters and too small cause corns, bunions, hammer toes, etc.

If your feet are cold at night, use wool bed socks or a small wool blanket around your feet.

### Corns and Callouses

Do not use corn remedies or cut corns or callouses with razor blades, scissors, etc.

Bathroom surgery and strong chemicals are a major cause of serious complications to the feet of a patient with diabetes and/or impaired circulation.

If you have corns or callouses, whether they are painful or not, advise your physician, if he is not already aware of this condition.

If home treatment of corns and callouses is necessary, softening agents such as castor oil, olive oil, or preferably lanolin may be applied twice daily. A small bit of lamb's wool or cotton, placed between the stocking and the callous formation, often gives relief. Never apply adhesive plaster or corn pads.

Many ulcers seen on the foot of a patient with diabetes and/or impaired circulation originally started under a corn or a callous. If a corn or a callous has a reddish or brownish discoloration around it or on it, seek medical attention at once.

Do not use strong antiseptics such as iodine, bichloride of mercury or phenol. Plain rubbing alcohol is probably one of the best antiseptic agents for you to use.

During treatment by the chiropodist, various appliances and padding may be supplied you for the purposes of removing irritation and pressure from calloused areas or bony prominences. These devices are for your benefit, and if well cared for will last for a long time.

If for some reason these devices are not comfortable on your foot, immediately discontinue wearing them and bring this fact to the attention of the chiropodist.

### Avoidance of Severe Temperature Changes

Even mild burning or chilling to the feet may precipitate one of the most difficult and dangerous situations you may encounter.

The blood flow to the feet may be diminished. Blood flowing through the tissues not only nourishes them, but also warms and cools them, as the need may be. Sudden exposure to extremely high or low temperatures may cause damage to the feet that would not ordinarily take place. You may have a tendency to develop dead areas on the skin, or so-called areas of low sensation. In view of this fact, extra precautions are necessary where temperature changes are involved.

Never use hot water bottles, heating pads, hot bricks, stones, flat irons, etc., to warm your feet.

Use caution in placing feet on or near heating registers, car heaters, heat lamps, etc.

Never bathe or soak the feet in hot water. Water should never be more than just pleasantly warm. Never put feet in water without first testing the temperature with your hands, or elbow.

Avoid cold situations and damp floors, since these contribute to poor circulation.

If your work exposes you to dampness, cool unheated quarters, low temperature, or high temperatures, or the spilling of hot materials, you should discuss the possible change of occupation with your physician.

### Care of the Toenails

Never trim nails with knife or razor blade.

Never dig in the cuticle at the nail edges.

Cut nails straight across and do not round corners.

The following is a good procedure for trimming nails:

1. Scrub with soft brush, mild soap, and warm (not hot) water. This will remove all dead tissue and will soften nails.
2. File nails, using a coarse file with a blunt tip or an emery board. Never use a pointed file. Do not file crosswise, as on the fingers, but from the top down. For extra hard nails, a regular six-inch, steel file, purchased at a hardware store, is very effective.
3. After filing again scrub with soft brush and soak in lukewarm water for no longer than five minutes, rinse well, and sponge with rubbing alcohol.
4. Any remaining tissue or soil under the nail edge or in grooves will usually work itself out with a few daily applications of cold cream, vaseline, or lanolin. Never attempt to dig it out. Never attempt to cut or push the cuticle. If it becomes hard, use cold cream or lanolin daily until it becomes soft.

If nails are thickened or horny, have a tendency to ingrow, are inflamed or infected, report this to your physician or chiropodist.

### Leg Cramping, Aching, and Painful Arches

If you have leg cramping, aching or painful arches, report these symptoms to your physician. Do not buy arch supports from some store or through an advertisement in some magazine. These may cause irritation and produce further damage. Examination of your feet will determine whether an arch support, special shoes, or some form of appliance is indicated.

### Foot Hygiene

Remember, the skin on your feet is the first line of defense against infection. Persons with diabetes and/or impaired circulation frequently have lowered skin resistance to infection. Consequently they develop skin irritations more quickly than do most people. Keep the skin of your feet clean, soft and pliable.

Enclosed is my contribution of $_____ to the Fund for the Advancement of Podiatry (Chiropody) Education.

I wish to ANNUALLY pledge $_____ to the Fund.

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Never trust "the feel of your feet" as a guide to their well-being. So-called dead areas or areas of low sensation are common in the patient with diabetes and/or impaired circulation. Since this is the case examine your feet daily for any spots of redness, blisters, signs of infection, etc. The best time to do this is during your daily foot bath. Remember, never trust "the feel of your feet"—look at them carefully. In many cases where this has been neglected, ulcerations and tissue breakdown have developed before pain was felt by the patient.

Wash your feet daily in warm (never hot) water with mild soap. A soft brush should be used gently on the nails and bottom of the feet. If you soak your feet in water over five minutes, gently massage lanolin-aquaphor ointment to them immediately following soaking.

Dry feet thoroughly with blotting action. Never rub vigorously. Be sure to rinse soap water from beween the toes. Dry between toes with soft towel or cotton.

If the skin shows signs of dryness, rub gently with lanolin-aquaphor ointment following bath. Wipe off excess with towel, if necessary.

### Skin Color

If your feet look unusually white or pale, or exceptionally flushed or red, or are bluish, call this fact to the attention of your physician.

### Some Don'ts for Your Foot Care

Don't sit with your legs crossed.

Don't tuck bed clothing too tightly over your feet at night.

Don't use any kind of vibrator without first consulting your physician.

*Veterans Administration Center*
*Wilshire and Sawtelle Blvds.*

## BOOK REVIEW

### BONE

Franklin C. McLean, Ph.D., M.D., and Marshall R. Urist, M.D., 181 pages, The University of Chicago Press, 1955.

The authors of this volume offer both a broad examination of the skeletal system and a deep insight into its fundamental problems.

This book meets the need for an understanding of the physiology and biochemistry of the bone. It goes far beyond the usual concern with the function of bone as providing the skeletal support of the body or with the adaptation and development of the individual bones. Instead, this book studies bone as a complex tissue with a variety of chemical and physiologic relationships.

The authors' approach bridges the gaps between the various disciplines, as they bring morphology, histochemistry, enzyme chemistry, experimental embryology, crystallography and electron microscopy to bear upon the problems of bone. Among the outstanding features of the book are the brilliant and complete discussions of the role of enzymes in bone, mineral metabolism, radioactive isotopes, the healing of fractures.

The book is organized into three parts: The chapter on the healing of fractures is the one that interested me most. This book is to be recommended to the podiatrist as good academic reading material, with special emphasis placed on the chapter on the healing of fractures. *S. M.*

## "FUND FOR THE ADVANCEMENT OF PODIATRY-CHIROPODY EDUCATION"

The American Podiatry Association has incorporated a "Fund" for the purpose of continuing, sustaining and advancing Podiatry-Chiropody Education.

WHY?

We shall try briefly to answer this question. It is common knowledge that many of the Podiatry-Chiropody Colleges in this country are engaged in a struggle for survival. Not enough students have been attracted to the study of Podiatry-Chiropody. The number of students presently matriculated at our professional schools bears this out. Even with a fully matriculated student body—in numbers that each school could teach adequately—it is questionable whether our colleges could exist and progress without some form of aid.

This problem is not peculiar to our profession alone. Medicine, dentistry and osteopathy—giants by numerical comparison—are having their own difficulties. These professions have attempted and put into being a number of plans to aid their respective colleges. Both medicine and dentistry have established "Funds" for the collection of monies to support their teaching institutions. At the beginning, contributions to these "Funds" were purely on a voluntary basis. Then many state medical, dental and osteopathic societies realized the needs and the problems of undergraduate education in their fields and what it meant to their chosen profession. Now cognizant of these matters they saw to it to have a direct assessment for education placed on each member. Even with this fixed amount of monies collected from individual members through state society dues, these professions are still "not out of the woods" as far as their needs go for their undergraduate education. However, a substantial beginning has been made. Physicians throughout the country are rather proud of themselves as a result of the progress they have made in contributing monies to their educational institutions, beginning seven years ago in 1950. Physicians contributed about $4 million in 1957 to their medical schools, $978,000 of this through their American Medical Education Foundation.

We are convinced that the sense of urgency is much greater on a relative scale in Podiatry-Chiropody. Ways and means must be found to attract an ever-increasing number of students to our schools, to enable our colleges to exist, teach, progress and keep their heads above water in the financial sense.

How can we keep our schools stable and operate successfully? Who has this direct responsibility? Obviously it comes back to each one of us—to every practitioner in Podiatry-Chiropody. We are the ones who simply must be concerned with the progress of education in our branch of the healing arts.

We have worked in and for our profession. Not too many years ago there were leaders in our profession who made sure that Podiatry-Chiropody became an established, recognized branch of medicine. They had the faith and the foresight. They had the courage to establish colleges to teach our specialty. Because of them we have reached a stature that was undreamed of only 20-25 years ago. Are we ready to see all this go by the board? Do we have the same determination as our predecessors? Don't we owe those who are to follow us a legacy of Podiatry-Chiropody education?

To what avail is increased scope of practice, inclusion in Blue Shield and similar health insurance plans, industrial podiatry, post graduate education with emphasis in

surgery, diagnosis and medicine etc.—all glowing plans for today and tomorrow—when a shadow is cast with possibly no future profession and therefore no tomorrow. This is hard reality and something that must pierce our consciousness before time runs out.

What we do now is the important thing. Hence the reason for incorporating and putting into being a "Foundation" that will explore, first within the profession and then without, every possible means of obtaining funds to keep our colleges alive and in being.

Much preliminary work has already been done. The Executive Council recommended a table of organization for our "Fund." A committee representing the Executive Council, the Council of Education and the Association of Chiropody Colleges, worked out details of a long range program. We think it will be all encompassing. As a result, our 1958 House of Delegates approved the establishment of the "Fund" and a Board of Directors has been elected.

The time is at hand now for all members of our profession to join in a cooperative effort to save the life blood and the future of our profession—one dedicated to the alleviation of human suffering.

We are realists. We know the "Fund" for the Advancement of Podiatry-Chiropody Education" will not have easy sailing in its endeavors to reach the goals set out in its prospectus. The need for urgent action is infinitely painful. Heroic tasks require heroic responses. We are confident our profession, when the chips are down, will not be found wanting. We are therefore asking you now to contribute $100 to the "Fund for the Advancement of Podiatry-Chiropody Education."

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## THE NATIONAL BOARD OF PODIATRY-CHIROPODY EXAMINERS

PIERCE B. NELSON, B.S., D.S.C.
San Francisco, Calif.

DURING the August 1956 convention in Chicago, the National Board of Podiatry (Chiropody) Examiners was born. This organization was brought into being after a pattern established by the National Board of Medical Examiners and the National Board of Dental Examiners. Both of the above organizations were helpful in establishing the framework of the organization.

The purposes for establishing such an organization were designed to be helpful to four groups: (1) The Podiatry-Chiropody students. (2) The Podiatry-Chiropody colleges. (3) The Federation of Podiatry-Chiropody Boards. (4) The profession of Podiatry-Chiropody.

The National Board of Podiatry-Chiropody Examiners, when properly established and adequately recognized, can be the instrument which provides a standard for our professional education and our individual State Boards of Examiners.

1. The National Board and the Podiatry-Chiropody Student—The policy of the National Board is to gather questions on material taught in our colleges from every possible source. These questions will then be organized and edited into proper examination form by a professional agency. The generally accepted best form for such questions is the multiple choice form which can be corrected by a machine. After the above agency has thousands of questions edited into proper form by professional educators, many examinations will be prepared on each subject. These examinations

will be administered in the various colleges on the same day in the following manner: Each student will be allowed or required (depending upon the college) to take an examination at the close of his second and fourth years of training. At the close of his second year he will be examined on the basic science subjects taught in his first two years. At the close of his fourth year he will be examined on his last two years of training. The examinations will be monitored and corrected by the agency with the results being sent to the student and his respective college. Tabulation of the results of such examinations will be available to all colleges and state boards on a national basis. This makes the student aware of exactly how he stands with his fellows nationwide. It should act as a definite incentive for the student to exert himself towards excellence in scholarship.

2. The National Board and the Colleges —It is usually difficult for any institution of higher learning to evaluate itself or to receive proper evaluation from the outside. There is no better yardstick of evaluation than educational achievements of its students. Examinations such as outlined above would aid the college administrators to better evaluate their own programs. For example, if students from a certain college rate consistently low in anatomy, then the administrator could re-evaluate his department of anatomy and make necessary changes to bring it up to standard.

The colleges could better evaluate the individual student. Satisfactory completion of these examinations could be used as requirements for advance standing and graduation from our colleges.

3. The National Board and the Federation—This program could work successfully with any State Examining Board. The individual state could accept the examinations as sufficient for licensure or they could require additional examinations as they see fit. These states requiring practical examinations might use the National Board examinations as adjuncts to their program.

It is certainly not the intent of the National Board of Podiatry-Chiropody examiners to usurp any of these prerogatives or authority of the individual state board. Each state can remain autonomous in its control over licensure of individuals entering that state. The National Board could provide a guide for individual states to closely examine and evaluate their own examining program.

4. The National Board and the Profession—The individual practitioner probably has the most to gain from the establishing of such a program. This program would guarantee to the individual that the "new foot-man" coming to practice in his locality has attained a certain minimum scholastic level. He can be assured that the "new graduate" has had certain basic training regardless of the college from which he graduates. The podiatrist-chiropodist will know that the educational standards of his profession are constantly being evaluated and elevated.

*1770 Eddy Street*

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"Everything that enlarges the sphere of human powers, that shows man that he can do what he thought he could not do, is valuble."

*James Boswell, 1791*
*Life of Samuel Johnson*
*Abram Leon Sachar, Ph. D.*

# TECHNIQUES IN FOOT SURGERY

L. R. McCAIN, D.S.C., F.A.C.F.S., and
N. J. PICKETT, D.S.C., F.A.C.F.S.

Editors, Publications Committee, A.C.F.S.

*Illustrated case reports and discussions, suggesting approaches to podiatric surgery, from the files of the American College of Foot Surgeons.*

## SURGICAL REMOVAL OF AN INTRADERMAL NEVUS

A FEMALE patient, aged 37, seen at the hospital, presented a pigmented nevus on the medial and superior border of the fifth toe left foot. The growth had appeared approximately four years previously, had become larger, and over a period of the past few weeks the patient had had discomfort in the fifth toe.

Roentgenograms indicated there was no involvement of the bone.

Urinalysis was negative for sugar and albumin. Blood count findings were: Hemoglobin 74.3%, W.B.C. 9,800, R.B.C. 3,730,000. Fasting blood sugar was 91 mg / 100 cc.

The patient was given Trinsicon®[1] Pulvules B.I.D. three days before surgery, this to be continued for a period of two weeks after surgery for the mild anemia.

The patient was given ¾ gr. Sodium Seconal®[1] one-half hour before surgery. The preoperative blood pressure was 130/80 and the preoperative oral temperature was 98.4°.

After aseptic procedure, anesthesia was effected by 2 cc. Xylocaine Hcl.®[2] 2% as a toe block. A tourniquet was placed around the fifth toe.

Operative technic was as follows: By means of two semi-elliptical incisions, the mass was excised including a good portion of the normal skin on all sides. The wound was carefully inspected and the skin edges were underscored for better coaptation. The skin edges were sutured and the incision covered with sterile Telfa®[3] and sterile plaques. The fourth and fifth toes were bandaged with a pressure dressing.

Postoperative medication was as follows: Ilotycin®[1] 250 mg. No. VIII; Sig: One tab. q. 6 h. For a sedative Seconal 1½ gr. H.S. if necessary. Analgesic was Empirin Comp. with Codeine Phos.®[4] gr. ½, Tab. No. VI, q. 4 hrs. P.R.N.

Postoperative treatment was as follows: The following day the patient's temperature and blood pressure were checked and the bandage was inspected. Postoperative pain was minimal. She took no analgesic or sedative. On the fourth day the dressing was removed. There was some maceration of tissue. The area was swabbed with Tr. Merthiolate and sterile dressing made. On the eighth day the sutures were removed. Bacitracin®[5] Ung. and sterile dressing applied. Three days later the wound was dry and healed except a slight area in the center. The wound was dressed with Bacitracin Ung. and sterile dressing applied. A week later the wound was dry, almost healed. 10% Ichthyol®[6] and sterile dressing applied. Five days later the wound was healed and the patient discharged.

Postoperative diagnosis was intradermal nevus. Pathological findings: Gross: The specimen consists of a piece of skin and subcutaneous tissue which measures 1.5 x .8 x .5 cm. The skin is covered by a cauliflower-like formation which measures .5 cm. in diameter. Micro: The epidermis is thin. The borders between the epidermis and underlying dermis are sharp. The dermis reveals a diffuse proliferation of

®[1] Lilly ®[2] Astra ®[3] Bauer and Black ®[4] Burroughs, Wellcome & Co. ®[5] Abbott ®[6] Schering

nevus cells arranged in nests and bundles. There is no evidence of malignancy seen.

*J. M. Kohl, D.S.C.*

*Comments:* The junctional nevus which is flat or only slightly raised, pigmented from light tan to black are particularly found below the knee and elbow. Many of these lesions are diagnosed clinically as a malignant melanoma. Forty percent of the growths of this type may be proven malignant histologically. Thus, the conclusion is that clinically, the diagnosis of benign nevus may not be accepted with any degree of accuracy. It is considered a normal prophylactic measure to remove any growth of this nature and especially at a sight where it may be subject to trauma. It goes without saying, a microscopic study of the involved tissue must be made by a competent pathologist.

*L. R. M. & N. J. P.*

## SURGICAL REMOVAL OF AN ACHILLES' BURSA

A female patient, aged 29, seen at the hospital, presented an inflamed bursa on the posterior aspect of the left heel. This area had been irritated originally about two years previous to this time by a pump type shoe.

Urinalysis was negative for sugar, and blood count findings were all within normal range.

Roentgenograms indicated no involvement of the bone.

The patient's preoperative temperature was 98.6 and blood pressure was 125/85. She was given ¾ gr. Sodium Seconal®[1] 30 minutes before surgery.

After aseptic procedure, anesthesia was effected by infiltrating 2½ cc. Xylocaine Hcl.®[2] in the area of the bursa. A Martin bandage was applied proximal to the area.

Operative technic was as follows: A lineal incision approximately 3½ cm. long was made at the medial aspect of the bursa. This incision extended from the superior to the inferior. The edge of the wound over the bursa was retracted and the bursa removed by blunt dissection. The wound was coaptated and closed with six 000 silk sutures. One cc. Achromycin®[3] was put into the wound by means of a sterile syringe. Sterile Telfa®[4] was placed over the wound and sterile pressure dressing applied.

The patient was given Emperin Compound with Codeine Phosphate®[5] No. 3. q. 3 h. if necessary.

Postoperative treatment was as follows: On the second day postoperatively the outer dressing was replaced. On the seventh day a complete re-dressing was made, and Tn. Merthiolate was placed on the wound. On the twelfth day, the sutures were removed, Tn. Merthiolate placed on the wound, and sterile re-dressing made. On the seventeenth day debridement was done and the patient dismissed.

The patient took only one of the Empirin Compound with Codeine tablets. Recuperation was without incident.

One year after the surgery the patient was completely comfortable and there was no indication of a return of the bursa.

*Comments:* Although this case responded excellently to surgical care, in many such cases there is also bone involvement. This, of course, complicates the procedure, but unless the involved bone is resected, there is a frequent recurrence of the symptoms.

*L. R. M. & N. J. P.*

®[1] Lilly

®[2] Astra ®[3] Lederle ®[4] Bauer and Black
®[5] Burroughs, Wellcome & Co.

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When the grass looks greener on the other side of the fence, it may be because they take better care of it.

*—Ivefor Gotten*

# PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

*A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.*

### Daxalan Ointment® Daxalan Pediatric Ointment

**Description:** Daxalan Ointment contains rigidly standardized whole crude coal tar 2.88%, zinc oxide 5.37% and starch 53.75% in a special emollient base. Daxalan Pediatric Ointment is a half-strength Daxalan Ointment with rigidly standardized whole crude coal tar 1.44%, zinc oxide 2.68% and starch 28.88% in a special emollient base.

**Indications:** Contact dermatitis, dermatophytoses, psoriasis, chronic dermatitis, occupational dermatitis, pruritus ani, pruritus vulvae, varicose ulcer, nummular eczema, atopic dermatitis, infantile eczema, exfoliative dermatitis, chronic exudative lichenoid and discoid dermatitis, winter eczema, neurodermatitis circumscripta mamillae.

**Administration:** Carefully remove all previous medication. Apply Daxalan to the lesion or affected area. Cover with light dressing and allow to remain undisturbed for three days or more, then repeat. For use of Daxalan with Dome-Paste Bandage, refer to Dome-Paste Bandage file card.

**Supply:** Daxalan Ointment in 2-2/3 oz. and 1¼ lb. jar. Daxalan Pediatric in 2¼ oz. and 1 lb. jar. By Dome Chemicals Inc., 109 West 64th Street, New York 23, N. Y.

### Kolpix® Creme (ph 4.8)

**Description:** A water-washable creme containing 2% rigidly standardized whole crude coal tar in the exclusive Acid Mantle® base.

**Indications:** Acute vesicular dermatoses, weeping eczema, infantile eczema, dermatophytoses, contact dermatitis, itching oozing vesiculation, allergic dermatitis (wet), psoriasis, psoriatic diseases, squamous scalp eruptions, lichen simplex, old excoriated skin, pruritus ani et vulvae, varicose eczema, varicose ulcers, occupational dermatitis, dermatitis venenata.

**Administration:** Prepare area with cold wet compresses of Domeboro® Solution, allow to dry and apply Kolpix. In scaly conditions remove all scales with soap and water and apply.

**Supply:** In 2 oz. and 1 lb. jars. By Dome Chemicals Inc., 109 West 64th Street, New York 23, N. Y.

### Methadone Hydrochloride (meth-a-don) Analgesic, Narcotic

**Generic Name:** Methadone Hydrochloride.

**Description:** Synthetic heptanone derivative; white, crystalline substance of bitter taste, soluble in water and alcohol.

**Action and Uses:** Orally and parenterally effective morphine-like analgesic possessing many of the pharmacologic properties of morphine with less sedation, narcosis or mental confusion. For use in controlling postoperative pain; in relieving pain in malignancy, renal colic, bladder spasm and other nonsurgical conditions; as cough depressant. Not recommended as analgesic in obstetrics or for preoperative sedation.

**Administration:** For moderate or severe pain, 2.5 to 7.5 mg. orally, or 2.5 to 10 mg. subcutaneously, repeated at 3 to 4 hour intervals if necessary. For children, adjust dose according to age and weight.

*Caution*: Narcotic, may be habit forming with addiction and dependence. Side ef-

fects, more frequent in ambulatory patients, include nausea, vomiting, dizziness, amnesia, pin-point pupils, stupor, mental or respiratory depression, diaphoresis, euphoria.

**Supply:** Methadone Hydrochloride Solution—Ampuls 1 cc. containing 10 mg. in boxes of 6 and 25. Vial multiple dose 20 cc., each cc. containing 10 mg. By Abbott Laboratories, 14th and Sheridan Road, North Chicago, Illinois.

Under the name of Dolophine Hydrochloride, Eli Lilly & Company of Indianapolis, Indiana, produces Methadone as follows: Ampuls, 1 cc. containing 5 mg. or 10 mg. per cc. in boxes of 12 and 100. Ampuls rubber-stoppered, 10 mg. per cc., 20 cc. in boxes of 12 and 100. Dolophine Hydrochloride Tablets (inscribed "Diskets") —Tablets of 2.5 mg., 5.0 mg., 7.5 mg., 10 mg. in bottles of 100 and 1000.

Massengill Company of Bristol, Tennessee, produces Methadone Hcl. in 10 mg. ampuls, 1 cc. boxes of 5. and vials of 10 cc., also in tablets as follows: 2.5 mg., 5 mg., 7.5 mg., in bottles of 100 and 500.

William S. Merrell Company of Cincinnati, Ohio, supplies this drug in solution—vial of 20 cc. each, containing 10 mg. in water for injection.

Upjohn Company makes sterile solution, 10 mg. per cc. in 30 cc. vials.

### Paraflex (Chlorzoxazone)
### Skeletal Muscle Relaxant

**Description:** Paraflex is a new orally effective specific for painful muscle spasm. Each scored tablet contains 250 mg. of Paraflex, which is 5-chlorobenzoxazolinone.

**Action:** The action of Paraflex is on the reflex mechanisms involved in the production of painful skeletal muscle spasm. Paraflex acts mainly on the spinal cord to inhibit transmission of nerve impulses through multisynaptic reflex arcs. The clinical effect is a reduction of muscle spasm with relief of pain and increased mobility of the involved muscles. The end result is more rapid recovery from painful muscle spasm with less discomfort and shorter periods of disability.

**Indications:** Paraflex is particularly useful in relieving pain and spasm associated with the following rheumatic, arthritic, and orthopedic disorders: muscular rheumatism (fibrositis), low back pain (acute and chronic), wry neck (torticollis), sprains and strains, myalgia, spondylitis, rheumatoid arthritis, cervical root syndrome, disc syndrome and osteoarthritis.

Paraflex is also useful in reducing spasticity associated with neurological diseases such as multiple sclerosis, cerebral palsy, dystonia musculorum, and traumatic spinal cord injuries. The degree of response obtained in neurological disorders with spasticity may be excellent in some cases and negligible in others.

**Administration and Dosage:** Adults—relief may frequently be obtained on a dosage of one tablet (250 mg.) 3 or 4 times a day. Initial dosage for severe spasm should be two tablets (500 mg.) three or four times a day. If adequate response is not obtained with this dose, it may be increased to 3 tablets (750 mg.) three or four times a day. As improvement occurs the dosage may often be reduced.

Children — the dosage of Paraflex for children is usually ½ to 2 tablets (125 mg. to 500 mg.) three to four times a day depending upon age and weight.

**Advantages:** Rapid action — peak blood levels. Side effects are rarely a problem. Especially suited to long-term therapy. No known contraindications, no cumulative action or habituation.

**Supply:** Available in the form of 250 mg., scored tablets, colored orange, in bottles of 50 tablets. By McNeil Laboratories, Inc., Philadelphia 32, Pennsylvania.

# PODIATRY-CHIROPODY ABSTRACTS

ROBERT SHOR, D.S.C.
4480 Crenshaw Bldg.
Los Angeles, Calif.

*Editors of Local, State and Regional Publications are requested to provide copies to the Chairman of the A.P.A. Committee on Publications.*

## PODIATRY RESEARCH—THE CHALLENGE AND OPPORTUNITY

Robert R. Krout, Current Chiropody, 7: 7-9, July 1958.

Krout emphasizes the need for research in our profession. He states, "there may be certain unknown factors about foot 'stress' and reaction besides the arthritides and the various circulatory diseases. It is for podiatrists who see the need for new ways of solving old problems to carry out, in their own ways, individual or group research projects.

To understand nature, by relating truths of anatomy, chemistry, physics, physiology, and even neurology, coupled with what is known about mechanics is necessary for those who would elevate our understanding of primary stressors to cause tissue reaction. One may find new directions for our profession to follow. The field of research is open to all who dare to put together the facts of nature in a more logical and effective manner, for the benefit of their patients and the enlightenment of our profession."

## FORMALDEHYDE AND VITAMIN A IN THE TREATMENT OF VERRUCAE

Murray P. Levey, Current Chiropody, 7:14-15, July 1958.

During the past three years Levey has combined formaldehyde (3%) soaks and the oral administration of Vitamin A capsules in selected wart cases with gratifying results. The solution of formaldehyde is used as a dehydrating agent and the Vitamin A to bring normalcy to the skin.

Levey outlines his procedure for treatment and the prescriptions used.

## LOCAL TREATMENT OF PSORIASIS

Morris Ant, M.D., Journal of Podiatry (New York), 7: 9-13, July 1958 (Reprinted from Medical Times. Dec. '57).

"In a series of 34 resistant cases of psoriasis, the use of Riasol benefited the cutaneous lesions in 33 cases (97%). In 11 cases (32%) all cutaneous manifestations of the disease were cleared completely.

There was relief of itching in 94% of cases, complete or partial disappearance of the scaliness in 91%, and fading of the erythema in 82%. There were no adverse effects.

The most effective ingredient of Riasol is the small percentage of mercury chemically combined with soaps. In this form, the mercury penetrates the superficial layers of the epidermis and combats the acanthosis or excessive proliferation of the prickle-cells located in the stratum mucosum.

Since Riasol contains only 0.45% mercury, it is safer than the 2 to 5% ammoniated mercury ointments in common use."

## TREATMENT OF GANGRENE OF THE FEET AND LEGS BY WALKING

William T. Foley, M.D., N. Y. J. of Pod., 8:10-18, Aug. 1958 (Reprinted from Circulation May 1957.)

Bed rest results in decreased blood flow. Disuse atrophy follows, bone is absorbed and muscles waste. One of the greatest stimuli to the development of collateral blood flow in the legs is walking.

The medical treatment used in the group of 22 patients being discussed was as follows:

Avoidance of tobacco.

Use of gravity. To aid the flow of blood into collateral channels, the affected limb was kept below heart level. Alternate filling the limb with blood and then draining it with positional changes was accomplished with the use of an oscillating bed.

Warmth. Reflex vasodilatation was produced by placing a heating pad over the abdomen for periods of ½ to 1 hour.

Vasospasm. To combat vasospasm sublingual nitroglycerin was used.

Use of anticoagulants.

Exercise used as a therapeutic measure afforded prompt relief of the intense pain heretofore experienced. While Dr. Foley did not find any reference in the literature to walking as a therapeutic measure in cases of gangrene, there are references to increased blood flow in the legs through walking.

Twenty-two patients are evaluated and a synopsis of each case is presented.

## CLINICAL REPORT ON A NEW PREPARATION FOR ONYCHOMYCOSIS

Raymond Strahs, Current Chiropody, 6:9. June 1958.

A new compound, Undine (Garret Laboratories, Clifton, N. J.), has been tried clinically in a series of cases of multiple onychomycosis over the past 20 months. This medication has a formula of undecylenic acid, benzocaine, iodine and a very effective surfactant and wetting agent, triethanolamine in an isopropyl alcohol vehicle. Iodine has been a proven fungicidal agent for many years but is utilized here for another role of equal importance. The iodine causes a dilitation of the deeper capillaries in the nail bed and matrix producing increased nutrition. This activity helps to stimulate new nail cell production.

Strahs, after studying 16 cases of onychomycosis with the above preparation, concludes that iodine in conjunction with undecylenic acid is an excellent formulation.

## EDEMA OF THE LOWER EXTREMITIES

Robert A. Guidice, Florida Footprints, 2:5-6, Sept. 1958.

The basic physiological changes are discussed in some of the more common entities associated with edema in an effort to review these principles and stimulate thinking along these lines.

Some of the common entities mentioned are heart trouble, physiologic edema, thrombophlebitis, postphlebitic syndrome, occlusive arterial vascular diseases, and inflammation.

## SURGICAL PROCEDURE FOR HELOMA MOLLE

Burton Bornstein, Florida Footprints, 2:3-4, Sept. 1958.

After a discussion of the radiographic findings and a presentation of the blood findings, Bornstein describes the following procedure for the correction of heloma molle in the web between the fourth and fifth toes.

A straight incision is made over the fifth toe at the proximal interphalangeal articulation. The incision was retracted and by blunt dissection the long extensor was exposed and resected. The proximal interphalangeal joint was entered and disarticulated. The head of the proximal phalanx was resected just below the neck of the bone. The operative field was closed with inverted mattress and vertical dermal sutures.

In about 21 days the heloma molle had completely disappeared, with no discomfort present in working shoes.

## DIGESTS FROM THE LITERATURE

*Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.*

### CIRCULATORY DISEASES

*Chronic Arterial Insufficiency of the Lower Extremities,* M. E. DeBakey, E. S. Crawford and D. A. Cooley. DM pp. 1-45, Feb. 1957.

This monograph describes the incidence, pathology, clinical manifestations, methods of examination and diagnosis, and treatment of this condition. Operative therapy consists of restoration of blood flow by thrombo-endarterectomy, blood vessel replacement, lumbar sympathectomy, together with supportive measures. Arteriosclerosis causing arterial insufficiency of the lower extremities can be easily differentiated from thromboangiitis obliterans. Arteriosclerosis occurs in patients over 40, unless precipitated by diabetes; thromboangiitis obliterans occurs in patients in the third and fourth decades. A pulsatile circulation can be restored in most patients having arteriosclerosis, but rarely in those with Buerger's disease. In 436 cases studied, there were 253 patients with occlusion of the aorta-iliac segment and 183 with occlusion of the iliofemoral level. Over 90 per cent of the total patients had restoration of circulation and symptoms relieved. Amputation was everted in approximately 20 per cent. Operative mortality was 2.9 per cent of the entire group. Good results were maintained up to four years, with a small incidence of recurrence.

*Clinical Entity of Anterior Crural Ischemia,* L. Blum. Arch. Surg. 74: 59-64, 1957.

Four cases are presented in which the clinical picture of anterior crural ischemia without gross distal tissue involvement was caused by arterial interruptions at different levels. Of these cases two were aorta-iliac emboli, one popliteal embolus, and one probably femoral artery thrombosis. The cause of this disease is diminution of blood supply to the muscle in the anterior crural compartment, which results from organic occlusion of the arterial vasculature of the extremity; or it may be due to unusual exertion in an individual susceptible to such a lesion. A causative factor may be a physiologic tendency toward accumulation of a high concentration of lactic acid in the muscle tissue. Effective treatment consists of early release of tension in the anterior crural fascia. Early embolectomy is remedial if the lesion is of organic origin.

*Varicosity and Ulceration of the Lower Limb; Clinical Follow-up Study of 247 Patients Examined Phlebographically,* E. Arenander. Acta Chir. Scand. 112: 135-44, 1957.

The prognostic significance of findings in phlebography of normal deep veins, such as slight changes or appreciable lesions and obliteration of deep veins, was studied in 279 lower limbs of 247 patients aged from 10 to 90 years. Of these, 168 showed clinical evidence of thrombosis and 121 extremities had ulcerations. Operations seemed advisable in most cases, but when phlebography did not show passage through the deep veins, radical removal of superficial varices seemed of doubtful value. The operative procedure usually used was high ligation and stripping of the saphenous vein down to the knee at least, local excision of varices, and usually injection of

monoetanolamine oleate into the distal stump. Small saphenous veins if incompetent were ligated. The superficial femoral and popliteal veins were not treated surgically. No operations were performed on patients without perceptible varices, those in whom phlebography failed to show passage through the deep veins, and those objecting to operation. Injection therapy of circumscribed varices and bandaging of the leg, wearing of elastic stockings and occasionally of a Unna's boot, were advised.

Follow-up was done after 2 to 5 years in 93 per cent of the 279 limbs. In those with normal deep veins and those with tortuous or dilated deep veins, most of the ulceration had healed. In those in which deep veins had showed earlier thrombosis, and those in whom contrast material failed to penetrate the deep veins, results of treatment, surgical and nonsurgical, were less satisfactory.

*How Can We Reduce the Number of Amputations in Patients with Disturbances of the Peripheral Circulation?* H. W. Päsler. Angiology 7: 528-31, 1957.

High amputation of a limb for initial gangrene in order to attain a primary closure is now considered poor practice. Special diagnostic methods, such as oscillometric examinations, aortography, arteriography of the peripheral vessels, etc. must be used to establish that the vascular tree of the opposite limb is normal, and prove without a doubt that there is no functional disturbance indicating a future obliterative process which might lead to amputation of the second limb as well. Conservative procedures are not sufficient if there is nocturnal or continuous pain which indicates imminent gangrene or tissue destruction; sympathectomy has proved successful in these patients with vascular disease of the lower extremities, alleviating the pain, and in incipient gangrene arresting the disease process. Adjuvant therapy recommended is intra-arterial oxygen insufflation and prolonged Depot-Padutin therapy, which is a slow intra-arterial infusion given at a speed of 10 to 30 cc. per hour. If pain occurs due to increased mortification of the toes and the anterior part of the foot, systemic treatment, including morphine, is imperative, and should be continued along with antibiotic therapy until an aseptic necrosis has developed. Partial amputation can then be done with safety. Removal of one or more toes rarely suffices; it is better to remove the whole anterior past of the foot either in the Lisfranc or Chopart joint line. Such surgical procedures are described.

Long drawn out conservative therapy is less successful than sympathectomy if performed early in cases of intermittent claudication, ischemia, and nightly or continuous pain without gangrene, to control the pain. If the process progresses or if peripheral pain appears, arterectomy is necessary (of the arterial tree) to demonstrate intact functioning of the collateral blood vessels to be preserved at operation. Early arterectomy before sympathectomy, or at the same time as sympathectomy, is not approved. Endarterectomy will suffice in patients with very small obstruction, as demonstrated by aortographs.

The patient with any type of surgery with or without amputation requires annual studies, or rechecks earlier if any aggression of his condition occurs, which should include oscillographs of all extremities. Intermittent therapy with vasodilators throughout life is advocated, preferably with Depot-Padutin. Patients under 65 should be warned not to smoke; older patients resent the restriction. Continued use of a conservative surgical treatment program has decreased primary amputation of extremities and restricted the amount and extent of secondary partial amputations. Amputation of more than one extremity in a patient is no longer necessary.

*Collateral Circulation in Health and Disease,* T. Winsor, J. H. Payne et al. Arch. Surg. 74: 21-28, 1957.

A study was made of the collateral circulation index in 15 normal subjects and in 20 patients with moderate arteriosclerosis obliterans. For normal subjects the average index was 3.0; for arteriosclerosis obliterans patients 7.0. For the latter, the average after posterior nerve block was 30.0 and after lumbar sympathectomy ranged between 14.0 and 32.0. Thus in arteriosclerotic obliterans patients after these operations blood flow becomes relatively greater in the height of pulsation as compared with normal subjects. In patients with arteriosclerotic segmental occlusion of the right femoral artery lying between the inguinal ligament and the profunda femoris blood pressure at the foot was 100 before and after manual compression of the femoral artery, indicating that the entire flow to the foot was through collateral channels, with no blood passing through the femoral vein.

In a patient having arteriosclerosis obliterans attended by an occlusion in the posterior tibial artery pressing on this artery did not alter pressure at the foot. Pressing on the dorsalis pedis caused pressure to fall too low to be measured. These studies showed that patients with arteriosclerosis obliterans have relatively low pulsations when compared with the volume rate of flow (high index). A high index was obtained in patients with moderate arteriosclerosis obliterans following posterior tibial nerve block or after lumbar sympathectomy. Sympathectomy therefore seems to dilate small vessels and permits an increased volume of blood flow without significantly increasing pulsations in the digit. In the presence of chronic obstructive arterial disease the collateral circulation can be of functional importance, but the amount of collateral circulation will not be the same in all patients, since it is affected by systemic blood pressure, speed of occlusion of the vessels, and presence or absence of potential collateral circulation.

## DERMATOLOGY AND ALLERGY

*Superficial Mycotic Infections of the Skin; Diagnosis and Therapy,* J. L. Callaway and S. Olansky. J. Chron. Dis. 5: 518-27, 1957.

Tinea pedis (dermatophytosis, 'athlete's foot') is the commonest form of superficial fungus infection. It occurs in chronic hyperkeratotic form, in chronic intertriginous form, and in subacute and acute form. The last is usually associated with a secondary infection; rupture of the vesicles and pustules may cause ulceration. Diagnosis can be made only by demonstrating pathogenic fungi in the lesion. Therapy of dry keratotic or chronic intertriginous lesions is soaking the foot for 30 minutes every night in permanganate solution or prophyllin solution. Following the soaking, Castellani's paint, Veredam, one-half strength Whitfield's ointment, Pragmatar ointment, or Desenex, Sporonol, or Asterol ointment is applied. In the morning a dusting powder is applied, such as Desenex, Sopronol or Asterol. Treatment should continue until the lesions cannot be seen (about one week). Dusting powder should be used indefinitely as a prophylactic therapy. Acute infected tinea pedis requires complete or modified bed rest with the feet elevated. Compresses of potassium permanganate solution, Burow's solution, prophyllin solution, or silver nitrate will be helpful. Debridement and clipping of vesicles and pustules are recommended.

*Plantar Wart; Recurrence After Curettage Under Local Anesthesia,* R. Hall. Brit. J. Dermat. 69: 95-96, 1957.

General anesthesia for removal of warts is used only when there are multiple lesions and are curetted in the hospital. Recur-

rence of warts situated on the plantar surface of the heel tend to recur when curettage is done under local anesthesia. A case is reported in which the lesion recurred within one month on the original site. A second curettage was done about two months after the first operation and showed a line of warty tissue along the track of the first needle puncture and a warty point at site of injection. Removal under general anesthesia has not been followed by recurrence.

*Surgical Treatment of Plantar Corns,* B. A. Rutledge and A. L. Green. U. S. Armed Forces M. J. 8: 219-34, 1957.

Plantar corn (clavus) can be distinguished from plantar wart (verruca) by removal of the superficial layer. A wart shows elongated dermal papillae with enlarged blood vessels and is sharply demarcated by a wall of fibrous tissue and a tenderness on side-to-side pressure. A corn shows a horny conical core of loosely packed epidermal cells in concentric layers; it is painful only on slight pressure. The operative procedure successfully used in 30 cases consisted of a short dorsal longitudinal incision over the affected metatarsal head, retraction of the extensor tendon, and the periosteum reflected; then the metatarsal was cut with a bone-cutter through the junction of the middle and distal one-third of the shaft. Excision of the metatarsal and head by sharp dissection was followed by rongeuring and rasping the rough portions of the distal end of the shaft. Bed rest and elevation of the foot for three to four days is the only postoperative therapy needed. The corn disappears in about eight weeks.

*Etiology of Dermatophytosis,* I. L. Maskin, C. L. Taschdjian, and A. C. Franks. Arch. Dermat. 75: 66-69, 1957.

A study made of the total cases diagnosed as dermatophytosis, whether due to Trichophyton mentagrophytes, T. rubrum, or E. floccosum, which were treated in the mycology section of a large hospital from 1935 to 1954, indicates that T. mentagrophytes have been gradually superseded by T. rubrum as the etiologic agent in that New York State area. The T. mentagrophytes dropped from 80 per cent to 20 per cent by 1954, but T. rubrum increased from 1.8 per cent to 10 per cent, per 100 cultures of dermatophytoses. The E. flocossum incidence has also dropped but to a lesser extent. That T. rubrum is the cause of most cases of dermatophytosis across the nation and is also worldwide is shown in the recent literature.

*Periorbital Dermatitis Following Adhesive Tape Strapping of the Lower Extremities,* W. A. Reyer. Ann. Allergy 15: 144-49, 1957.

Four cases are described in which a chiropodist had applied corrective adhesive strapping for 6 to 12 weeks before periorbital dermatitis developed. By the time the eruption appeared about the eyes, pain and swelling in the feet and legs were minimal and the leg ulcers were healing. Penicillin ointment had been used in the two patients with ulceration, but they showed no sensitivity to penicillin. The pathogenesis of this periorbital dermatitis is uncertain, but the suggestion is made that since these patients had a long-standing circulatory inadequacy of the feet, legs or both from foot strain or painful ulceration, when the spastic muscles became relaxed by relief of pain through strapping, tissue-protein metabolites may have entered the circulation in pathogenic amounts. When an area of skin such as the eyelids developed a sensitivity to these metabolic elements over a period of months, a dermatitis possibly developed through suddenly increased amounts of the metabolites in the circulation. The disorder was mild and self-limiting, and relief was maintained by use of soothing washes and sedation. Chiropodic care did not need to be discontinued.

## DIABETES, GANGRENE

*Management of Gangrene in the Extremities,* S. S. Samuels. Angiology 7: 532-36, 1957.

Before a major amputation is decided upon, three factors must be evaluated: (1) the status of the arterial circulation both instrumentally and clinically and the warmth or coldness of the limb in various positions, to indicate the adequacy of blood supply; (2) the patient's general condition—cardiac status, renal function, anemia, diabetic control; (3) control of any infective process, particularly of a gangrenous area. Daily foot soaks of green soap and warm water for 10 to 15 minutes will keep the area clean and soften the leathery gangrenous tissues; boric acid ointment dressing should follow the soaking. A case is described of a patient with diabetes uncontrolled and general condition poor, who refused amputation. Incision and drainage of a plantar abscess, and debridement of gangrenous tissue were followed by daily applications of a dressing of Neosporin ointment. The considerable bleeding during the manipulations indicated that collateral circulation was sufficiently controlled by conservative treatment. The end results four months later were good. In cases where collateral circulation is insufficient, conservative treatment is not advisable.

*Infection and Gangrene in the Foot of Diabetic Patients: Virtues of Conservatism,* E. Downie and M. O'Connor. Australia & New Zealand J. Surg. 26: 194-97, 1957.

Management of infection or gangrene in the middle-aged or elderly is different from that in younger patients. Usually there is an insidious impairment of blood supply slowly progressive and often symptomless. An insensitivity of the foot due to peripheral neuritis and trauma to the skin and soft tissue go unnoted. Radical amputation should be done only if the infection threatens life or is impossible to control, or if gangrene is so extensive the foot cannot be restored, or if there is intractable pain. The patient should be taught proper care of the feet, washing and drying, applying no local heat, avoidance of ill-fitting shoes and darned socks, care in cutting nails and calluses, and avoidance of corn cures. A slight injury can cause inflammation and endanger vascularity when already there is an inadequate blood supply. Treatment of infection caused by organisms with broad band antibiotic ointments containing bacitracin, neomycin, etc. may control the infection before tissue damage occurs. If not, infection may spread into foot tissues along the tendon sheaths. Parenteral use of antibiotics is not efficient because the blood supply to the foot is too poor to allow effective concentration of the drug at the infected site.

Following conservative treatment, at a later stage, amputation of one or more toes may be necessary. The stump if appropriately treated can be made serviceable for many years. The mechanics of preparing a slipper prosthesis to be applied is described. Then shoes must be properly fitted and built up to overcome the imbalance caused by loss of toes or a large part of the foot, by use of a Thomas heel with an inner buttress of up to ¼ inch, and be fitted with a domed metatarsal bar on a convex rocker bar. The patient using the prosthesis with a modified shoe uses a walking machine at first, walking with a rocking movement beginning at the knee joint. He soon learns to walk without crutch or stick.

## MUSCULOSKELETAL SYSTEM

*Treatment of Injuries Involving the Subtalar Joint,* C. DeBold, Jr., and B. B. Stimson. Amer. J. Surg. 93: 604-08, 1957.

Major injuries which involve the subtalar joint are either fractures of the os calcis which completely disrupt the joint or cause fracture lines extending into the

joint to produce a hemarthrosis, or are dislocations of the joint. Most treatments have proved unsuccessful with disability extending from 6 to 8 months, and even leaving some permanent disability. However, by focusing attention on motion at the subtalar joint many of the complications can be lessened and the period of disability shortened. The procedure used is: after adequate x-ray study, the patient is treated by elevation of the foot of the bed, sedation, and application of cold compresses at the time of admission, then lumbar sympathetic block within 24 hours; 24 hours later application of hot packs and use of exercises are begun. The patient is out of bed in 5 to 7 days walking on crutches; at 8 weeks he is allowed weight bearing, usually wearing an inner heel wedge. The average loss of time from work has been 11 weeks in this group of 18 patients followed up. Some osteroarthritis is present in all cases but usually is nonsymptomatic. Prolonged immobilization may cause stiffness; scarring and adhesions being tight cause difficulty if non-motion is prolonged. Full range of motion is preferred to avoid loss of function of the joint and impairment of foot function.

*Joint Contractures in Children,* Browne, D. Proc. Roy. Soc. Med. 50: 69-70, 1957.

These contractures may be congenital or acquired, and may be intrinsic or extrinsic. Intrinsic contracture may occur *in utero* because of pressure causing interference with normal blood circulation. This pressure may be due to inadequate expansion of uterine structures (mechanical), or to increased tension of the amniotic fluid (hydraulic). The results of the increased hydraulic pressure are (1) muscles failing to develop properly and (2) therefore a thickening of the fibrous tissue around the joints. Hydraulic compression affects all limbs equally. There is often a history of hydraminios during the pregnancy and the child is born with extended hips because of the over-large cavity; those developing in a cavity too small have compression of the legs and feet. The arms may be caught straight down alongside the body. The flexed wrists and knees are not due to structural deformity but to lack of function; immobility weakens the muscles. Extrinsic factors in contracture are abnormal positions *in utero,* causing clubfoot and metatarsal varus; or are due to mechanical compression causing metatarsal valgus. Such deformities should be remedied before the child sits up and walks, or body weight and unbalanced muscular action will cause rapid increase of the curve, leading to idiopathic scoliosis.

Acquired contractures result from unbalanced muscular action, caused by cerebral palsy or poliomyelitis. In the former it is due to greater power in the muscles of the calf than in those dorsiflexing the foot; in the second there is paralysis of peronei and extensors of the ankle. Bedclothes pushing on the foot downward and inward augment these factors. The author has designed an equinus splint to be applied at night to prevent the common fixed deformity. He treats ankles with acquired contracture by working them gradually into calcaneus by a series of walking plaster casts applied without anesthetics, until satisfactory range of movement upward is attained, after which it is maintained by the equinus night splint. He condemns the common tenotomy of the tendon achilles.

---

A sad-looking character was telling the psychiatrist his troubles. "I just can't go on, Doctor. Life is too hectic, too confusing. I've lost all desire to try."

"Of course," sympathized the doctor. "I understand perfectly. What you need is a year or so of treatment. We all have our problems. The fee will be about $50 a week."

The patient thought this over, then said: "That solves your problem, Doc. Now what about mine?"

## ORGANIZATION NEWS

*Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.*

### ILLINOIS

The Illinois Interprofessional Council announced that Dr. Edgar D. Coolidge of Evanston, Illinois, renowned dental research worker and educator, has been named to receive the 1958 Distinguished Service Award of the Illinois Interprofessional Council which represents more than 10,000 members of the health professions.

Dr. Philip R. Brachman, Past President of the Illinois Chiropody Society, announced the Award as President of the Interprofessional Council.

Dr. Peter N. Varzos, Chairman of the A. P. A. Committee on Nomenclature, was Chairman of the Selection Committee.

### REGION 10

The Dixie Region met at the Peabody Hotel in Memphis, Tennessee, with Old Man River (Dr. George D. Scherer) and his colleagues as Host. An outstanding social and scientific meeting was presented.

Featured scientific lecturers were Drs. Dale Austin of Los Angeles, California, and Louis Zulli of Philadelphia, Pennsylvania. The A. P. A. representatives attending and speaking were President-elect Dr. Marvin Shapiro and Dr. Joy Adams, member of the Executive Council.

Kentucky will be host state for the region in 1959, with the meeting to be at the Brown Hotel, Louisville, Kentucky, October 9-11, 1959.

Region officers elected for the forthcoming year are: President, Dr. James H. Glauber; Vice President, Dr. Leo Oppenheimer; Secretary-Treasurer, Dr. C. A. Nava.

### MICHIGAN

#### Wayne County Division

The Wayne County Division of the Michigan Chiropody Association met on December 2, 1958 in the Veterans Memorial Building in Detroit, Michigan, with Dr. Harry Lindy, Vice President, presiding.


**"LIFE'S FOUNDATION — YOUR BABY'S FEET"** is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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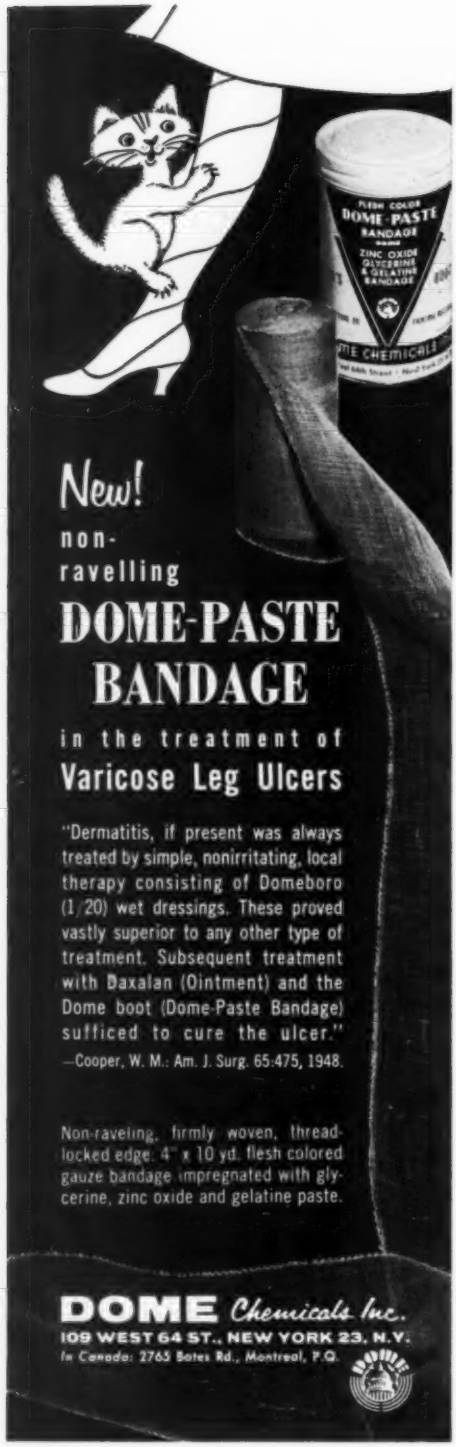
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—Cooper, W. M.: Am. J. Surg. 65:475, 1948.
Non-raveling, firmly woven, thread-locked edge. 4" x 10 yd. flesh colored gauze bandage impregnated with glycerine, zinc oxide and gelatine paste.
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Dr. M. Madgy lectured on Balance Therapy and held a discussion on Appliance Fabrication.

The regular board meeting preceded this meeting.

## MINNESOTA

The quarterly meeting of the Minnesota Association of Chiropodists was held December 6-7, 1958 at the St. Paul Hotel. Dr. A. C. Larson of Hibbing, Minnesota, demonstrated a "quick cast" technique for moulded shoes. Dr. Milo E. Peterson, Professor of Agricultural Education, University of Minnesota, spoke on "Attitude."

A representative of the Schering Pharmaceutical Company presented a film on corticosteroid injections and spoke on other drugs used by our profession.

The business meeting covered such items as Blue Shield and state legislation which would introduce podiatry into the state practice act.

In conjunction with this meeting, the Minnesota Foot Surgical Society held its first session.

## NORTH CAROLINA

The annual midwinter meeting of the North Carolina Chiropody Association was held January 24-24, 1959 at the Hollywood Hotel, Southern Pines, North Carolina.

## PENNSYLVANIA

### Philadelphia Chiropody Society

At the November scientific meeting of the Philadelphia Chiropody Society, held at the County Medical Building, guest speakers were Louis A. Soloff, M.D. and R. Robert Tyson, M.D., who lectured jointly on "Lower Extremity Manifestations of Cardiac Disease."

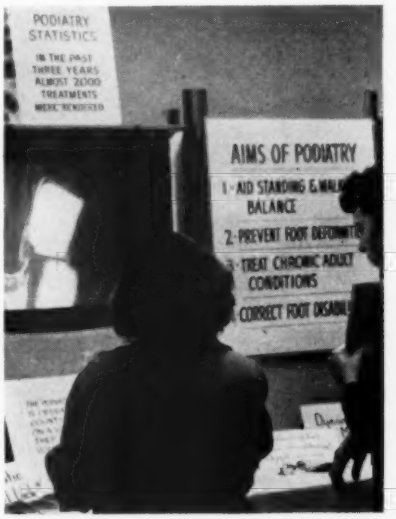
The December scientific meeting of the Philadelphia Chiropody Society was held on Tuesday, December 16, at the County Medical Building. Guest speaker, Joseph Horwitz, D.S.C., lectured on "Essentials of Low Voltage Therapy."

Dr. I. Daniel Greenfield was program chairman for these meetings.

## NEW YORK

### Nassau County Division

This exhibit was displayed on Sunday, October 19 at the United Cerebral Palsy Center, Roosevelt, New York, by the podiatry staff of the institution. It was presented in conjunction with an open house at the Nassau County CP Center during the telethon fund raising campaign. Hundreds of people viewed the display which was highlighted by color slides of various procedures.


PODIATRY STATISTICS
IN THE PAST THREE YEARS ALMOST 2000 TREATMENTS WERE RENDERED
AIMS OF PODIATRY
1- AID STANDING & WALK BALANCE
2- PREVENT FOOT DEFORMITI
3- TREAT CHRONIC ADULT CONDITIONS
CORRECT FOOT DISABI

Following are podiatrists on the staff of the United Cerebral Palsy Center: Director—Dr. Ira Fink of Baldwin; Assistant Director—Dr. Leonard Sherer of Merrick; Consultant—Dr. Emanuel Sugarman of Rockville Center; Staff Members—Drs. Martin Rakow of Cambria Heights; Mark Lowell of Massapequa; Herbert L. Green of Hewlett; Frank Greenberg of Valley Stream; Murray Edelstein of Wantagh; S. S. Masters of Mineola; Leonard Rosenberg of Garden City; David Skliar of Valley Stream; Alton Jacobson of New Hyde Park.

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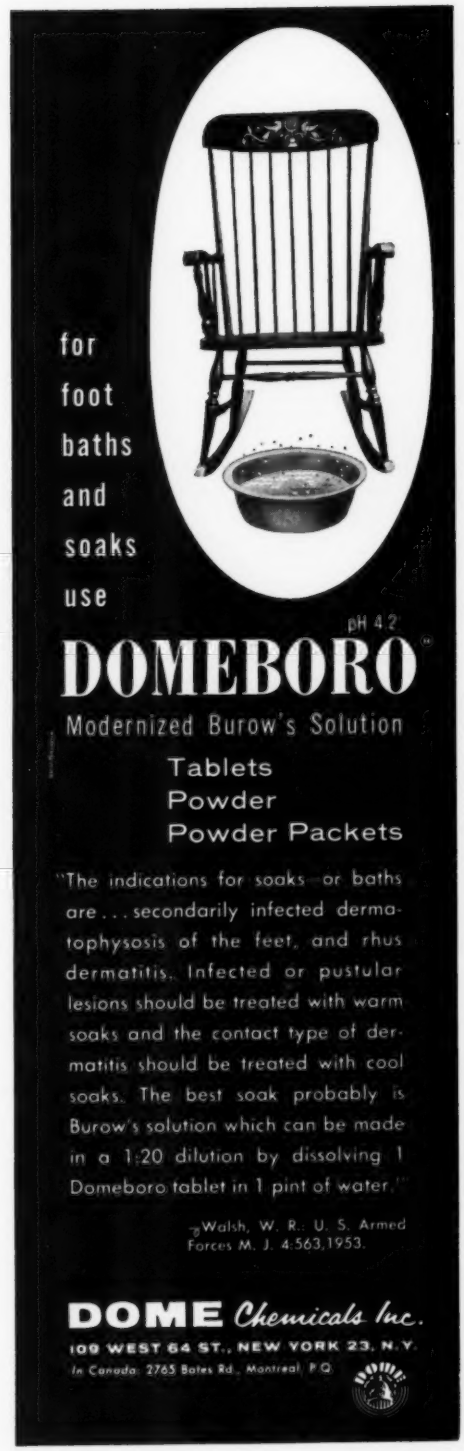
"Genius may conceive but patient labor must consummate."

Horace Mann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-Walsh, W. R.: U. S. Armed Forces M. J. 4:563,1953.
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## MARYLAND

The Maryland Chiropody Association arranged for display of the A.P.A. Vocational Guidance Exhibit at the Maryland State Teachers Convention. It was one of more than 100 exhibits (also including one by the Maryland Medical Faculty). Over 16,000 teachers attended the meeting. Available for distribution were "Chiropody As A Career," college catalogs and the information sheet from the Department of Health, Education and Welfare.

Exhibit of Maryland Chiropody Association at Maryland State Teachers Convention, October 16-17, 1958. (Left) Dr. Kenneth Hankin, (Right) Dr. Michael Sherman.

Chairman of the committee arranging for this exhibit was Dr. Michael Sherman, with Dr. Charles Stein, President of the State society, as co-chairman. Close cooperation and guidance was maintained with the A.P.A. Vocational Guidance and Audio-Visual Committees and especially Drs. Horowitz, Thompson, Shapiro and Greenfield.

## NEW JERSEY

The New Jersey Chiropodists Society has arranged with the Department of Postgraduate Medical Education, Seton Hall College of Medicine and Dentistry, for a series of postgraduate courses for members in the New Jersey Chiropodists Society. There are eight sessions on successive Wednesdays starting January 7th on Chiropodical Medicine including Psychosomatic Aspects.

There are five sessions on Clinical Dermatology on successive Fridays, beginning


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# VACATION - EDUCATION IN FABULOUS LAS VEGAS

THE AMERICAN COLLEGE OF FOOT SURGEONS ANNOUNCES ITS SECOND MID-WINTER SCIENTIFIC CONCLAVE TO BE HELD AT THE RIVIERA HOTEL, LAS VEGAS, NEVADA

FEBRUARY 16-17-18, 1959

Ask anyone who was there last year. The most enjoyable convention ever attended. By popular demand the American College of Foot Surgeons is returning to the magnificent Riviera Hotel. More elegant than ever, the Riviera has many added features—plus a new lecture auditorium.

The Scientific Program is designed to present the latest developments in forefoot surgery.

MONDAY—February 16

| | |
|---|---|
| Psychological Aspects of Foot Surgery | DR. LOUIS NEWMAN<br>Philadelphia, Penna. |
| Research in the Application of Metallic Sutures | DR. RUSSELL SEEBURGER<br>Detroit, Michigan |
| Five-Year Study of 1200 Metatarsal Head Resections for Plantar Keratomata | DR. THOMAS AMBERRY<br>Long Beach, California |

TUESDAY—February 17

| | |
|---|---|
| Practical Clinical Photography | DR. EDWARD TORNOW<br>Los Angeles, California |
| The Surgical Correction of Digital Deformities | DR. LYLE McCAIN<br>Chicago, Illinois |
| Surgical Management of Freiburg's Infraction of the 2nd Metatarsal Head | DR. LESTER WALSH<br>Midland, Texas |

WEDNESDAY—February 18

| | |
|---|---|
| The Exercise of Surgical Judgment | DR. ROBERT BRENNAN<br>Los Angeles, California |
| Discussion of Written Questions on Previous Papers | |
| Hallux Valgus: Its Surgical Treatment | DR. HENRI DuVRIES<br>Chicago, Illinois |

MONDAY EVENING 6:00-7:00—Cocktail party for all registrants and guests of the A.C.F.S.

TUESDAY 2:00—Luncheon for all registrants and guests of the A.C.F.S.

A Special Program will be provided for the wives so as to enable each doctor to deduct his wife's expenses.

Half Day Scientific Sessions—Top Floor Show Every Evening ! ! !

REGISTRATION FEE: Members—$25.00; Non-Members—$35.00
Advance Registration Fees should be sent to Dr. Gordon Tobin, 153 3rd Ave., N., Twin Falls, Idaho.

LAS VEGAS: The Entertainment Capital of the World

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March 6, and five sessions on Surgical Anatomy of the Foot on successive Wednesdays, beginning April 15.

The committee consists of Milton E. Ashur, D.S.C., Chairman; Saul Israel, D.S.C.; Jack Behar, D.S.C.; Clarence Bookbinder, D.S.C.; Mario Calligaro, D.S.C.; Leonard Hymes, D.S.C.; Harry Lamparelli, D.S.C.

## ILLINOIS COLLEGE OF CHIROPODY

Alumni of the college have formed the Alumni Education Foundation of the Illinois College of Chiropody and Foot Surgery. This is a non-profit corporation whose sole purpose is to obtain funds for teaching and research at the college. Following are the officers and members of the Foundation: Curry L. Meyer, D.S.C., President; Stewart E. Reed, D.S.C., Vice President; Lola T. Riesgraf, D.S.C., Secretary; George F. Fitzgerald, Treasurer.

If you wish any further information, please write to the Alumni Education Foundation, 25 E. Washington Street, Chicago 2, Illinois.

## CALL FOR YOUTH FOOT CARE WEEK STATISTICS

The failure on the part of many local and divisional Youth Foot Care Week Chairmen to report on the number of children's examinations made during this program is seriously hampering the Foundation's efforts to complete its statistical report. Despite repeated requests for this information, the lack of cooperation is placing the AFHF and the profession in a most embarrassing position in fulfilling inquiries as to these findings.

This data is vitally necessary in order to follow up and continue the overall program relating to American Youth Fitness.

Without this information it is impossible for the Foundation to answer the requests for it which have come from important government agencies, educational and health authorities and industry.

Any and all statistics available on children's examinations should be sent at once direct to Dr. Sidney Hirschberg, 107-07 Continental Avenue, Forest Hills 75, N. Y. for tabulation.


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## THE AMERICAN ACADEMY OF PSYCHOSOMATIC PODIATRY

The American Academy of Pyschosomatic Podiatry was organized at a meeting held for that purpose at the California College of Chiropody on November 18, 1958.

The object and purpose of the Academy is to bring together on a national basis members of the podiatry-chiropody profession who are vitally interested in these specialties with their relationship to the human foot, to promote educational programs and to encourage podiatry research and publication in this aspect of podiatry-chiropody.

Charter membership is limited to 100 applications and will be accepted up to and including March 31, 1959, whichever occurs first. All applications must be accompanied by the application fee and first year's dues in the amount of $25.00. Annual dues for membership thereafter will be $12.00.

Address all inquiries to the Organizational Secretary, Dr. M. C. Nuddleman, 468 13th Street, Oakland, California.

## DEATHS REPORTED

**Frank Bonville, Philadelphia, Pa.**

Dr. Bonville, a retired Philadelphia chiropodist, passed away on November 25 at the age of 84.

**Thomas T. Boyd, Boston, Mass.**

**William Cogley, Chicago, Ill.**

**Eugene H. Farley, Bluefield, W. Va.**

**C. L. Glendore, St. Louis, Mo.**

**E. M. Mayne, Philadelphia, Pa.**

**Arthur A. Moccia, Everett, Mass.**

**Louise B. Potter, Kansas City, Mo.**

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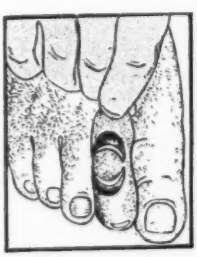

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## REPORT TO THE MEMBERSHIP

**Committee on State Society Membership**

Membership has always been important if a group or society is to accomplish anything. We have had a loyal membership in Chiropody-Podiatry throughout the years as is evidenced by the many advances our profession has made. If we are not to become stagnant we must continue to grow. It is what we all want and yet there is a tendency toward laxity on the part of many of us after a step forward has been accomplished. Membership is the key to continued progress. To this end your chairman has asked the Membership Chairman of each of our State Societies to serve on the State Society Membership Committee. Some states have many problems concerning membership, others seem to have found a solution. If we can have an exchange of ideas which may help us toward our potential goal of 100% membership—then continued progress is in the making. It was very gratifying to hear from each State Society in reply to the questionnaire concerning their State Membership Chairmen. This is the kind of cooperation we need, without it nothing can be done. All members are urged to introduce the non-member to the advantages of membership. Invite the non-member to your meetings and, (this is important), make him feel welcome. Your local membership chairman should be well qualified and active in the performance of his duties. By all working together we will continue to grow—for the public good demands our growth.

Membership is a Privilege.

J. C. Pankratz, D.S.C., Chairman

---

## WOMEN'S AUXILIARY MESSAGE

At the beginning of another year instead of looking back let us look forward to the future and what it can hold for each of us. It has been said that you are today where your thoughts have brought you and you will be tomorrow where your thoughts take you. The possibilities for us are endless if we will just take a little time to assemble our thoughts, to take inventory. The strides that have been made in just a few short years in nuclear energy, electronics, miracle drugs have sometimes been almost beyond our comprehension. How many of us gave any thought to the possibility of satellites in orbit? Yet today we listen to our news reports for further developments.

One of the most difficult problems of every individual who wants to get more out of life is the problem of breaking away from prejudices so that things can be seen clearly and objectively.

If we want a change for the better we must try doing the best we can, with what we have, where we are. It's all right to aim for the sky if everything's under control.

Our goal should be so to live that we make the best use of our talents, that we preserve to the end the health and strength of our bodies, that we keep our minds keen and alert and that we keep peace with our conscience.

Achievement in any walk of life is not an easy thing to come by. It takes a lot of ability and considerable energy. It always spells hard work and it has a way of eluding those who just want to stand and wait.

How much more intelligent we would be if we learned to take change philosophically and realize that while yesterday never stays or comes again there is always tomorrow!

Thelma Cooper, R.N., President

## CONVENTION DATES AND MEETING NOTICES

**American Podiatry Association**
New York, N. Y., August 27-Sept. 1, 1959
Waldorf-Astoria Hotel
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

**Region One**
(Conn., Maine, Mass., N. H., R. I., Vt.)
Boston, Mass., Sept. 25-27, 1959
Sheraton Plaza Hotel
Dr. Francis B. Powers
19 Dale Ave., Gloucester, Mass.

**Region Two**
(New York)
New York, N. Y., Feb. 20-22, 1959
Barbizon Plaza Hotel
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

**Region Three**
(Del., Md., N. J., Pa.)
Atlantic City, N. J., May 7-10, 1959
Ambassador Hotel
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

**Region Four**
(Ohio)
Columbus, Ohio, May 21-23, 1959
Deshler-Hilton Hotel
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

**Region Five**
(Ill., Ind., Mich., Wis.)
Chicago, Ill., March 20-22, 1959
Morrison Hotel
Dr. Earl G. Kaplan
14608 Gratiot Ave., Detroit 5, Mich.

**Region Six**
(Colo. Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Kansas City, Kans., April 10-12, 1959
Town House Hotel
Dr. Reid L. Cox, Gen. Chairman
409 Huron Bldg., Kansas City, Kansas

**Region Seven**
(Idaho, Mont., Oreg., Wash., Wyo.)
Vancouver, B. C., Spring, 1959
Norm Matthews, D.S.C.
Suite 322, 604 Columbia St.,
New Westminster, B. C.

**Region Eight**
(D. C., N. C., S. C., Va.. W. Va.)
Norfolk, Va., June 10-15, 1959
Aboard M. V. Arosa Sun
Dr. Irwin T. Domsky
2780 S. Randolph St., Arlington, Va.

**Region Nine**
(Florida)
Gainsville, Florida, May, 1959
Dr. Joy E. Adams
401 Florida Natl. Bank Bldg.,
St. Petersburg, Fla.

**Region Ten**
(Ala., Ga., Ken., Mo., Tenn.)
Louisville, Ky., Oct. 9-11, 1959
Brown Hotel
Dr. Chester A. Nava
4140 Shelbyville Rd., Louisville, Ky.

**Region Eleven**
(Ark., La.. N. Mex., Okla., Texas)
Southwestern Chiropody Congress
Little Rock, Ark., June 17-20, 1959
Marion Hotel
Dr. W. C. Gigerich, Gen. Chairman
Arkansas Natl. Bank Bldg., Hot Springs, Ark.

**Region Twelve**
(Ariz., Cal., Nev., Utah)
Western Chiropody Congress
San Francisco, Calif., May 29-30, 1959
Mark Hopkins Hotel
Dr. Alfred G. Roos
209 Post St., #412, San Francisco 8, Calif.

**American College of Foot Surgeons**
Las Vegas, Nev., Feb. 16-18, 1959
Riviera Hotel

**Phi Alpha Pi National Chiropody Fraternity**
Scranton, Pa., Feb. 6-8, 1959
Hotel Jermyn


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## LEGAL AND LEGISLATIVE

### PREPAID HEALTH PLANS

At its regular meeting, November 25, 1958, the Board of Trustees of the Medical Surgical Plan of New Jersey formally adopted a resolution authorizing payment to eligible chiropodists by the plan for eligible services coming within the scope of their licenses.

## HOSPITAL SERVICE NEWS

### HONOLULU, HAWAII

Annual report of the Queens Hospital, Honolulu, Hawaii, reveals that they have established a podiatry service in their outpatient department.

### PHILADELPHIA, PA.

The St. Luke's and Children's Medical Center, Philadelphia, Pennsylvania, Department of Podiatry, presented a postgraduate seminar on December 14, attended by over 150 podiatrists-chiropodists from the Philadelphia-South Jersey area.

James C. Giuffrè, M.D., Medical Director at St. Luke's, opened the seminar.

Lecturers were Jay H. Davidson, M.D., on "Reactions to Office Medications"; Frank A. Mattei, M.D., on "Immobilization"; Victor Dolfman, M.D., on "Syncope and Shock."

Carmine F. Travaglini, Chief of the Podiatry Department, acted as moderator and was assisted by Drs. Joseph Fabii, Herbert Felix, Arthur E. Helfand, Earl Horowitz and Donald Rodwin, staff members, in arranging the program.


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## MOOD ELEVATORS

**Contributions to this column are more than welcome. In fact it depends upon them.**
**A.O.P.**

Now, look, George, I already know what I think—so don't try to confuse me with a lot of facts.

*Domestic conversation reported by John H. Long, Jr.*

---

Henry, don't take another cocktail. Your face is already getting blurred.

*Wife overheard by Perrin C. Galpin*

---

"By the time a couple can afford to go out evenings, they can't leave the grandchildren alone."

*Marcelene Coy*

---

"There's no tax on this perfume—the type of man it attracts isn't considered a luxury."

*Salesgirl overheard by Mike Connolly*

*(Continued from page 21)*

### References


1. Clayton, M. L., Trott, A. W., Ulin, R.: *Recurrent Subluxation of Ankle with Special Reference to Peroneal Nerve Block as a Diagnostic Aid,* J. Bone and Joint Surgery 33-A, 502-504, April 1951.
2. Steele, Marshall K.: *Diagnostic Criteria of Fibular Collateral Sprain of the Ankle,* Armed F. Med. J., Vol. 7, January 1956.
3. Bonnin, J. G.: *Injuries to the Ankle,* Grune and Stratton, Inc., New York, N. Y., 1950.
4. Anderson, J. G., Le Cocq, J. F.; *Recurrent Anterior Subluxation of Ankle Joint,* J. Bone and Joint Surgery, 34 A, 853-860, October 1952.
5. Anderson, K. J., Le Cocq, J. F.: *Operative Treatment of Injury to Fibular Collateral Ligament of Ankle,* J. Bone and Joint Surgery, 36-A, 825-832, July 1954.



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# ANNUAL MEMBERSHIP DIRECTORY

## Corrections and Additions

This page may be removed from the *Journal* and placed in your Directory. It contains a listing of new members whose names reached national headquarters before December 10th. Those with an asterisk (*) are corrections of errors in listings as they appeared in the Directory.

May we suggest that you check the address on your *Journal* envelope to see that we have your correct address for the '59-'60 Directory, on which work has already started.

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Brooklyn, New York

Leon, Robert
1367 E. 17th Street
Brooklyn New York

Loman, Sadie
305 Convent Avenue
New York, New York

Paul, Saran A.
271 Sullivan Place
Brooklyn, New York

Rauch, Howard
1055 Blake Avenue
Brooklyn, New York

Resnick, Martin M.
2167 Cruger Avenue
Bronx, New York

Ritchie, Stewart Jay
12 John Street
Kingston, New York

Roth, Fred
612 Brighton Beach Avenue
Brooklyn, New York

Silverman, Jack J.
15 Cypress Road
Eastchester, New York

Teisch, Stuart
1330 Morris Avenue
Bronx, New York

Tilles, Harvey G.
1423 Avenue "I"
Brooklyn, New York

Tirnauer, Monroe H.
215 Mt. Hope Place
Bronx, New York

Unger, Leslie M.
2856 West 24th Street
Brooklyn, New York

Weinberger, Wilbur
8750 Bay Parkway
Brooklyn, New York

Weinstock, Robert E.
5 Client Road
Great Neck, New York

Wolff, William A.
150 South Broadway
Nyack, New York

Yesian, Arthur
1656 Paulding Avenue
Bronx, New York

**NORTH CAROLINA**

Huff, Arnold B., Jr.
405 Southeastern Bldg.
Greensboro, North Carolina

**OHIO**

Buchan, Robert
318 East State Street
Columbus, Ohio

Cannady, James A.
922 Collingwood Avenue
Toledo, Ohio

Caron, F. Evans
1304 Addison Road
Cleveland, Ohio

Dinda, Andrew J.
504 Niles Bank Bldg.
Niles, Ohio

Dull, Ronald B.
534 N. Park Avenue
Warren, Ohio

Fisher, Kenneth M.
948 Frederick Boulevard
Akron, Ohio

Hacker, Arnold
10616 Euclid Avenue
Cleveland, Ohio

Hilderbrand, Lawrence R.
2657 Cleveland Avenue
Columbus, Ohio

Leshner, David George
20119 Van Aken
Shaker Heights, Ohio

Maloney, Thomas L.
Hotel Secor
Toledo, Ohio

Perrone, Michael A.
1121 Cleveland Avenue, N. W.
Canton, Ohio

Pietro, Curtis P.
605 N. Wooster Avenue
Dover, Ohio

Rehak, Stephen A.
15703 Libby Road
Maple Heights, Ohio

Zucker, Albert K.
2854 Sylvania Avenue
Toledo, Ohio

**OKLAHOMA**

Davis, Elvin H.
206 Mayo Bldg.
Tulsa, Oklahoma

Pike, Charles M.
228 Koehler Bldg.
Lawton, Oklahoma

**OREGON**

Boileau, Michel A.
1220 Selling Bldg.
Portland, Oregon

Williams, Homer K., Jr.
431 S. E. Main
Roseburg, Oregon

**PENNSYLVANIA**

Evins, Raphael J.
4222 Ferne Blvd.
Drexel Hill, Pennsylvania

Fishman, Leonard
1122 Main Street
Darby, Pennsylvania

Goldstein, Harry B.
Suite 334, Connell Bldg.
Scranton, Pennsylvania

Larson, Clarence R.
211 W. 8th Street
Erie, Pennsylvania

Murtha, Raymond E.
738 Main Street
Honesdale, Pennsylvania

*Oestreich, George E.
1308 Erie Avenue
Philadelphia, Pennsylvania

Reynolds, William B.
201 N. Hanover Street
Carlisle, Pennsylvania

Rhoades, Charlotte R.
135 Gay Street
Phoenixville, Pennsylvania

Ristine, Merkel Wm., Jr.
946 Market Street
Marcus Hook, Pennsylvania

Segall, Martin
N. E. Corner 54th & Diamond Streets
Philadelphia, Pennsylvania

Serbin, Martin E.
5604 Penn Avenue
Pittsburgh, Pennsylvania

Sindoni, Anthony P.
10 West Dorrance Street
Kingston, Pennsylvania

Stiffler, John H.
209 Fisher Bldg.
Johnstown, Pennsylvania

Stolbach, Manuel J.
304 Connell Bldg.
Scranton, Pennsylvania

Wahl, Charles L., Jr.
416-417 Empire Bldg.
Pittsburgh, Pennsylvania

Weiss, Oliver F.
411 E. Main Street
Carnegie, Pennsylvania

Witherow, Samuel
103 Copeland Bldg.
New Kensington, Pennsylvania

**RHODE ISLAND**

Feldman, Seymour
106 Touro Street
Newport, Rhode Island

Greenberg, Melvin
27 Mayflower Street
Providence, Rhode Island

**TENNESSEE**

Skwor, Donald R.
1306 Exchange Bldg.
Memphis, Tennessee

**TEXAS**

Barnhart, William S.
2713 West Berry
Fort Worth, Texas

Cooley, Rosa L.
701 N. Washington Street
Odessa, Texas

Watson, William A.
825 W. 7th Avenue
Amarillo, Texas

**VERMONT**

Hayes, Jeremiah J.
181 Bank Street
Burlington, Vermont

**VIRGINIA**

Anderson, Jesse N., Jr.
800 E. Brambleton Avenue
Norfolk, Virginia

Suher, Bernard
3103 W. Franklin Street
Richmond, Virginia

**WASHINGTON**

*Keating, John A.
606-607 Joshua Green Bldg.
Seattle, Washington

Lawson, Harry D.
1032 E. 65th Street
Seattle, Washington

Uno, John H.
1032 E. 65th Street
Seattle, Washington

**WEST VIRGINIA**

Garrison, James W.
634 Hawley Bldg.
Wheeling, West Virginia

**WISCONSIN**

Davis, Richard C.
1419 Washington Avenue
Racine, Wisconsin

Francar, Gordon J.
1211 E. Walnut
Green Bay, Wisconsin

Kortsch, Kevin P.
9122 W. Center Street
Milwaukee, Wisconsin

Pedersen, Vernon R.
2224 Roosevelt Road
Kenosha, Wisconsin

Riedel, Thomas A.
1925 W. Hampton Avenue
Milwaukee, Wisconsin

Vigneau, Edmund U.
502 3rd Street
Wausau, Wisconsin

**AUSTRALIA**

Newton, George E.
200 Parker Street
P.O. Box 32
Cootamundra, N.S.W.
Australia

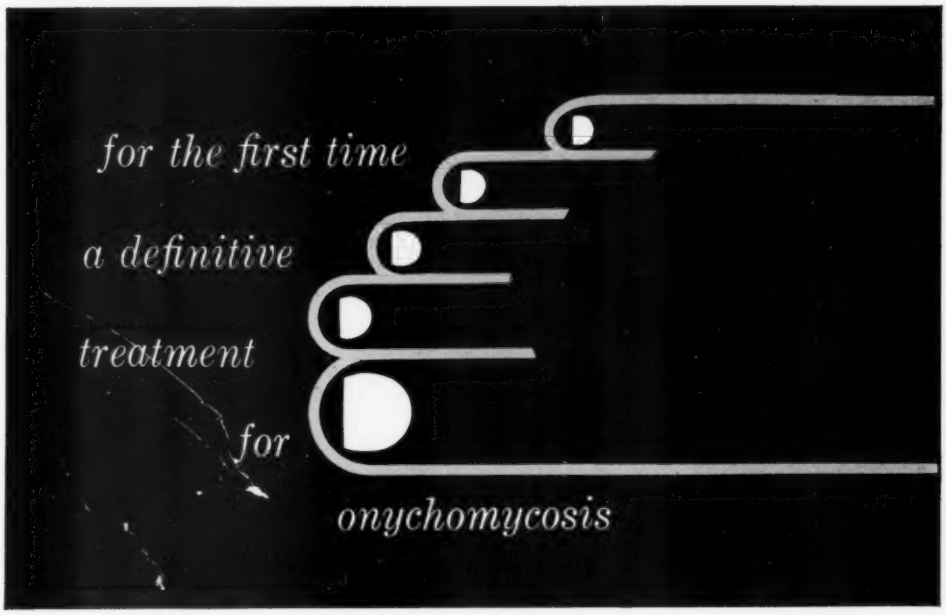
**FRANCE**

*Ducrey, Raymond
31 Rue Boissy D'Anglas
Paris, France

**PUERTO RICO**

Garcia, Jose Romeu
Suite 304, Professional Bldg.
Santurce, Puerto Rico

Mercado, Julius
Box No. 6
Corozal, Puerto Rico

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FORMULA: each cc. contains

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| Borotannic Complex (Derived from: Tannic Acid—46 mg. Boric Acid—29 mg.) . | 75 mg. |
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| Ethyl Alcohol (by volume) ..... | 56% |

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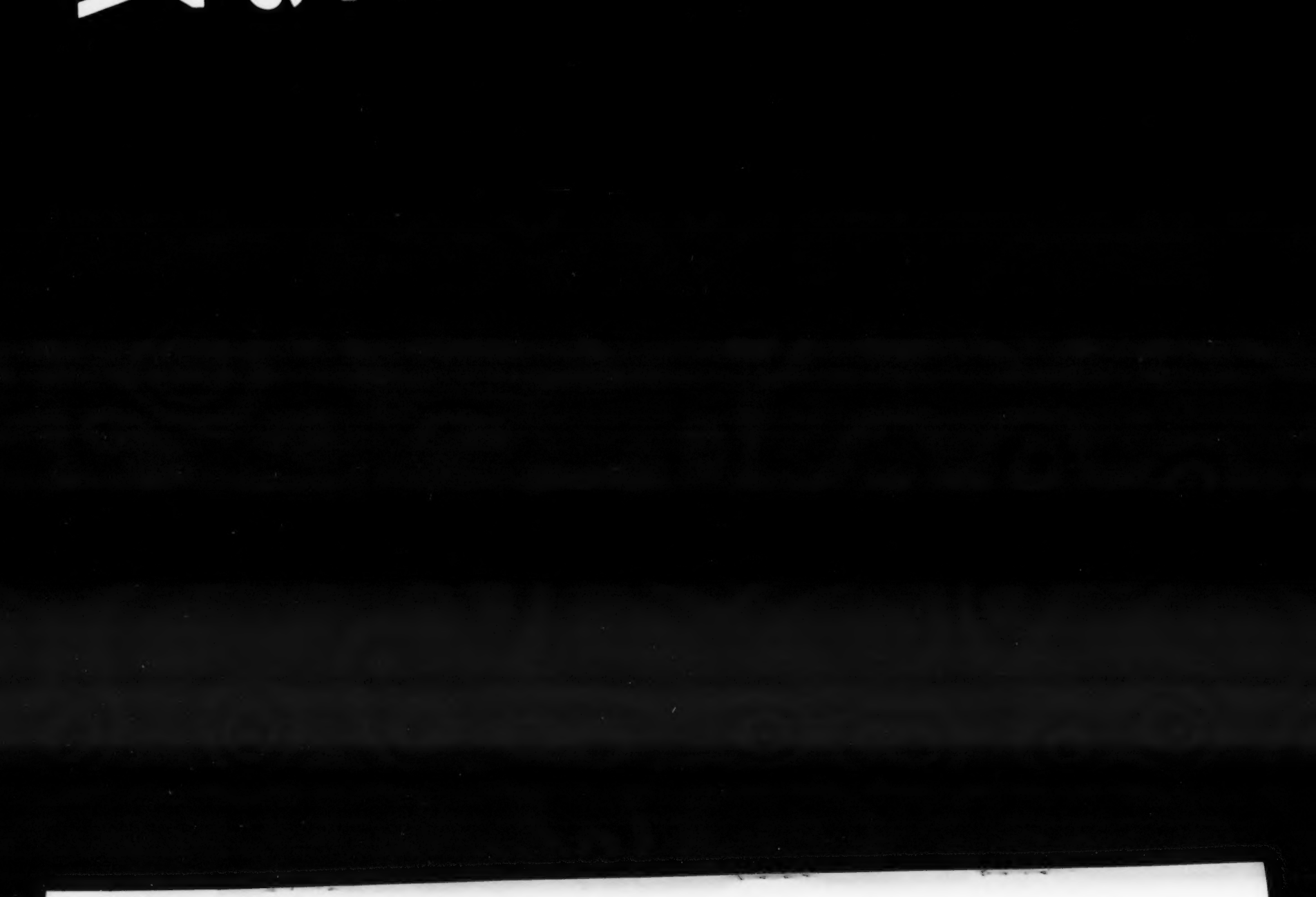
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